

# Enrollment / Change Form

Group Name: **Diocese of Fort Wayne-South Bend, Inc.**  
 Group Number: **3323175**  
 Diocese Location Number: \_\_\_\_\_

## A. EMPLOYEE INFORMATION

DATE OF HIRE \_\_\_\_\_

Last Name		First Name, MI		Social Security Number	
Street Address					
City		State		Zip	
Telephone _____					
Other Health Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
If YES, Name of Plan: _____					

**INSTRUCTIONS:** Check the box(es) that apply and complete the sections indicated:

	Change Reason	Change Date
<input type="checkbox"/> New Employee A B C D	_____	_____
<input type="checkbox"/> Enrollment Change A B C D	_____	_____
<input type="checkbox"/> Name/Address Change A, D	_____	_____
<input type="checkbox"/> Dependent Add/Termination A B C D	_____	_____

## B. COVERAGE INFORMATION: Mark the coverage desired. Mark "waive" for any coverage not elected.

	Self	Self/Spouse	Self/Child(ren)	Family	Waive		Self	Family	Waive
MEDICAL PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MEDICAL HDHP / HSA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DENTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HSA ANNUAL ELECTION*	\$ _____		
VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(*Payroll deductions will be taken pre-tax)			

**C. DEPENDENT INFORMATION:** Complete this section only if dependent coverage is chosen in Section B. Dependents must be eligible for coverage under the terms of the Plan. To expedite enrollment, complete section E-Request for Extended Dependent Coverage for any child over the age of 18, and/or section F-Statement of Responsibility for any dependent (spouse or child) with a last name that is different than your last name. If your eligible dependents are covered by any other group benefit program or MEDICARE, mark "Yes" in Other Health Coverage below and write the plan name in the box. If they have no other coverage, mark "No".

	Name	Sex	Date of Birth	Social Security #	Add-Date	Term-Date	Full-time Student?	Other Health Coverage?	Name of Plan
Spouse							N/A	<input type="checkbox"/> Y <input type="checkbox"/> N	
Child							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Child							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Child							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Child							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

**D. AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize any doctor, hospital, insurance company, employer or organization to release any information regarding history, treatment, disability, or benefits for claims to Anthem Blue Cross Blue Shield of Indiana. A copy of this authorization shall be valid as the original.

**I UNDERSTAND THE FOLLOWING:** This form will be used for benefit information and as a claim form. The information listed above is correct and true. To verify incorrect information on this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct from my pay my contribution (if any) to the cost of the benefits I have selected. If I am declining enrollment for myself or my dependents because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 30 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 30 days after that event. Please be advised that this plan contains a pre-existing exclusion for health care services. The exclusion lasts 12 months from your effective date of coverage or the beginning of any applicable waiting period prior to your effective date of coverage. You or your spouse or dependents may be able to reduce the applicable pre-existing limitation by providing proof of prior health care coverage. You should have received a Certificate of Health Care Coverage from your previous health plan or employer. If you need any assistance in obtaining proof of prior coverage, please contact your current Plan Administrator.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**PORTABILITY CREDITS:** In certain instances, benefits may not be payable for pre-existing conditions (illnesses or injuries for which medical advice, diagnosis, care or treatment was recommended or received prior to the effective date of coverage). If a pre-existing provision applies, each participant has the right to prove prior creditable coverage, including the right to secure a certificate from a prior plan of coverage. Let us know if you need assistance in obtaining a certificate of prior coverage. Please review pre-existing condition limitations in your summary plan description. Attach all certification forms verifying prior health plan coverage dating up to 18 months prior to this application, unless your employer advises you that you do not have to provide certification form(s).

- Certification form(s) are attached.
- Certification form(s) will be forwarded when received from prior benefit plans.
- This provision does not apply to me.

Name and phone number of prior carrier: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_