DIOCESE OF LA CROSSE LAY GROUP BENEFITS ENROLLMENT & CHANGE FORM

Admin Use Only - Effective Date: ____________

PARISH/INSTITUTION ______________________ **City** ____________ **#** ____ **Group #** L06588

EMPLOYEE INFO

Last Name ____ First Name ____ MI ____ Birth Date ____ Social Security Number ____

Street Address ____ City ____ State ____ Zip ____ Personal Email ____ Phone Number ____

☐ Single ☐ Female

☐ Married ☐ Male Job Title ____ First Date of Work / First Date of Eligibility ____ Hours / Week ____

PURPOSE OF FORM ***(Must mark one box)*:**

☐ **NEW EMPLOYEE** (*Eligible the first of the month, following First Date of Work*)

☐ **OPEN ENROLLMENT** (*Specific period of time to enroll or make changes*)

☐ **CHANGE**

- ☐ Termination / Resignation / Retirement / Reduction of Hours to ______ Hours / Week Last Day of Work / Eligibility ______
- ☐ Name Change New Name ______ Former Name ______
- ☐ Dependent(s)
  - ☐ ADD ☐ Delete Name ______ BIRTH DATE ______ SS# ______ RELATION ______
  - ☐ ADD ☐ Delete Name ______ BIRTH DATE ______ SS# ______ RELATION ______
- ☐ Qualifying Event ______

State the Qualifying Date and the Qualifying Event - - *(Marriage / Birth / Loss of Coverage / Newly Eligible / Divorce / Etc.)*

MEDICAL / VISION / DENTAL ELECTION – ***Must select an election or select WAIVE***

Medical ☐ Employee ☐ Family ☐ WAIVE

Plan & Deductible ☐ TRADITIONAL DEDUCTIBLE ☐ HIGH DEDUCTIBLE/HSA

Vision (Included w/Medical if Enrolled) ☐ Employee ☐ Family ☐ WAIVE

Dental ☐ Employee ☐ Employee & 1 dependent ☐ Family ☐ WAIVE

OTHER INSURANCE COVERAGE As of your effective date, will there be any other insurance in effect on you or any dependents to be covered? ☐ No ☐ Yes

If Yes, Primary Insured Name ______ Carrier ______ Group/Policy # ______ Effective Date ______

Dependents Covered ______ **Medical** ☐ Employee ☐ Family **Vision** ☐ Employee ☐ Family **Dental** ☐ Employee ☐ Family

LIFE INSURANCE ELECTION

BASIC LIFE / AD& D ☐ **$30,000** ☐ **WAIVE** *If not elected at start of employment, evidence of insurability may be requested to enroll in the life insurance plan.*

Primary Beneficiary ______ Relationship ______ % ______

Contingent Beneficiary ______ Relationship ______ % ______

Community Property State Consent for residents for Wisconsin: If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his/her rights to any community property interest in the benefit.

As the Employee's spouse, I do hereby consent to the beneficiary designation(s) indicated and waive any rights I may have to the proceeds of such life insurance under applicable community property laws.

Spouse Signature ______ **Date** ______

DEPENDENT INFORMATION (***List all dependents to be covered under this plan)****:*

	Name (Last, First, Middle Initial)	**Sex (M/F)**	**Birth Date**	**Social Security Number**
Spouse				
Child				
Child				
Child				
Child				

**If additional dependents, please list on next page*

MEDICAL RELEASE / ACCEPTANCE / AUTHORIZATION

I hereby authorize any doctor, hospital, insurance company, employer, or organization to release any information regarding history, treatment, disability, or benefits, but excluding genetic information and family history, for claims to Diocesan Third Party Administrator. A copy of this authorization shall be valid as the original.

I UNDERSTAND THE FOLLOWING: This form will be used for benefit information. 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 31 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 31 days after that event.

I certify the above is true & correct and acknowledge I have been given the opportunity to enroll in the Diocese of La Crosse Group Health, Vision, Dental, & Basic Life Insurance Plans. By not enrolling in certain benefits at this time, I realize I will not be able to enroll or make changes again until the next open enrollment unless I have qualifying event or family status change.

______ ______

Employee Signature *(Required)* ***Date***

See Reverse Side for Additional Important Information

OTHER IMPORTANT PLAN INFORMATION

Notice of Enrollment Rights:

I am aware that if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I have other coverage, I may later apply for coverage for me and/or my dependents if eligibility is lost under that other coverage, if the employer stops contributing toward the other coverage or if adding a dependent due to marriage, birth, adoption or placement for adoption. Loss of eligibility may result from one of the following:

1. My spouse loses coverage due to job termination or has a reduction in hours to a status that is ineligible for coverage;
2. My spouse and I divorce;
3. My spouse dies; or
4. The expiration of COBRA for a previous employer.

I am aware if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I do not want coverage for whatever reason, I may later apply for coverage for myself and/or my dependents with a marriage or the birth adoption or placement for adoption of a child.

In addition, you may add a new dependent to your plan as a result of a marriage, birth, adoption, or placement for adoption. Application to add a new dependent must be made within 31 days of the event.

If you qualify for enrollment under any of the above exceptions you must complete and return the signed application to your employer or St. Ambrose Financial Services, Inc. within 31 days of the qualifying event. When adding a dependent to your existing policy, you must complete and return a signed change form to your employer or St. Ambrose Financial Services, Inc. within 30 days of the marriage, birth, adoption, or placement for adoption.

You may also apply for coverage for you and any eligible dependent during the open enrollment period each year.

Eligibility and Effective Date of Coverage:

For newly hired employees, coverage is effective the first of the month following employment in a benefit eligible position.

Age Limits for Dependent Children:

Coverage for eligible children will cease at the end of the month in which the child reaches the age of 26.

If you have any questions about eligibility of particular enrollment changes, contact St. Ambrose Financial Services at 608-791-2669

ADDITIONAL DEPENDENT INFORMATION (***List all dependents to be covered under this plan):***

	Name (Last, First, Middle Initial)	**Sex (M/F)**	**Birth Date**	**Social Security Number**
Child				
Child				
Child				
Child				
Child				
Child				
Child				