Member Application / Change Request Form for Group Coverage

I. EMPLOYER MUST COMPLETE THIS SECTION AND CHECK APPROPRIATE BOXES:

Group Name		Group Number		
DIOCESE OF YAKIMA		**46270**	☐ New Employee ☐ Adding Dependent(s) ☐ Coverage Change ☐ Address Change ☐ Name Change ☐ Transfer to Self-Pay	☐ Terminate Coverage for: ☐ Subscriber ☐ Spouse ☐ Child(ren) Reason for termination:
Location Name/DIOC#	Indicate Salary / Hourly			

I hereby certify that all employment information specified above is accurate and complete X_____ Date:_____
Employer Representative

Employment Information:

Original Hire Date	_____/_____/_____
Date of Rehire	_____/_____/_____
Date Transferred from Part- to Full-time	_____/_____/_____
Hours Worked Per Week	_____
Open Enrollment	☐ Yes ☐ No
Special Enrollment	☐ Yes ☐ No
INTENDED EFFECTIVE DATE	_____/_____/_____

II. EMPLOYEE MUST COMPLETE THE FOLLOWING (IF WAIVING COVERAGE, PLEASE COMPLETE WAIVER SECTION ON REVERSE SIDE):

Subscriber's Name (last, first, middle initial): _____ Marital Status: ☐ Single ☐ Married Date Married:_____

Address: _____ City: _____ State: _____ Zip: _____ Home Phone: (_____)_____

Email Address: _____

Benefit Election (Please check below the coverage each participant is applying for – Plan Choice applies to all enrollees))						**If new employee, please list all covered dependents and check the add box. If change to existing eligibility, please check add or delete box and list dependent information.**				
Med	Den	Life	VSP Vision	**ADD**	**DEL**	**Last Name First Name M.I.**	**Relationship**	**Sex**	**Birthdate (M/D/Y)**	**Social Security #**
☐	☐	☐	☐	☐	☐		**Self**	☐M ☐F	/ /	- -
☐	☐		☐	☐	☐			☐M ☐F	/ /	- -
☐	☐		☐	☐	☐			☐M ☐F	/ /	- -
☐	☐		☐	☐	☐			☐M ☐F	/ /	- -

Disabled Child/ren Eligibility:

- If a dependent member meets plan requirements for a medical condition or physical or mental impairment and is approved by Health Services, the member may be eligible to remain insured beyond the dependent age limit defined in the plan. Disabled dependent status may be granted on a temporary basis for a period of one year (Temporary Disability), subject to annual review, or permanent status (Permanent Disability) for as long as eligibility is current. Required documentation for eligibility review includes completion of the Disabled Dependent Certification, signed by the member's physician, and a signed HIPAA release form in order to obtain medical documentation to support the member's disability. Please provide names of disabled children listed above: _____

Life Insurance: You may list one or more beneficiaries. List additional beneficiaries on a separate sheet of paper and attach it to this enrollment form. If listing one beneficiary, that individual will receive 100% of the benefit. If listing multiple beneficiaries, please indicate the percentage of the benefit each is to receive. The total percentages must equal 100%.

Beneficiary: _____ SS#:_____ Address:_____ Relationship: _____ %:_____

Beneficiary: _____ SS#:_____ Address:_____ Relationship: _____ %:_____

Note: Enrollment in the plan will not be processed if this enrollment form is submitted incomplete, including the applicant's signature and date signed. Notify the plan immediately of a change in address, or within 31 days of a change in status, over age dependent addition or special enrollment opportunity, or within 60 days of a birth, adoption or placement for adoption.

Additional Health Coverage Information

Are you or any covered dependents enrolled in Medicare? ☐ Yes ☐ No
If yes, please check the following: ☐ Part A ☐ Part B ☐ Part D
If yes, is this entitlement due to a disability or ESRD? ☐ Disability ☐ ESRD
HIC Number: _____ Effective Date: _____

Are you, your spouse and/or covered dependents currently enrolled in another group health plan? ☐ Yes ☐ No

Name of person covered by this carrier:	Date of Birth:	Type of coverage:
_____	_____	☐ Medical ☐ Dental
_____	_____	☐ Medical ☐ Dental
_____	_____	☐ Medical ☐ Dental
_____	_____	☐ Medical ☐ Dental

If medical and/or vision is checked above the following information is required:

Name of insurance carrier:_____

Phone Number: _____ Effective Date of Coverage: _____

Subscriber Name: _____

Plan Number: _____ Group Number: _____

Note: Enrollment in the plan will not be processed if this enrollment form is submitted incomplete, including the applicant's signature and date signed. Notify the plan immediately of a change in address, or within 31 days of a change in status, over age dependent addition, special enrollment opportunity, marriage, birth, adoption or placement for adoption.

Refusal of Coverage Waiver:

If you are declining enrollment for your dependent(s) (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 31 days of loss of the other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption you may be able to enroll your dependents, provided that you request enrollment within the enrollment timeframes outlined in your plan document.

I have been given an opportunity to enroll myself and/or my dependents in the group medical and dental coverage offered by my employer. After serious consideration, I/We have decided to decline enrollment for the following people in this plan:

Check person this waiver applies to:

☐ Employee ☐ Medical / Vision
☐ Spouse ☐ Medical / Vision
☐ Child/ren (list names) _____ ☐ Medical / Vision

☐ Covered by another group insurance program or Health Maintenance Organization.

Employer _____ Policy #_____

Name of Insured _____ SSN _____

☐ Covered by Champus or retired Military.

☐ Other (please explain) _____

_____

I understand that if I later wish to apply for coverage for myself and/or my dependents under this plan, I may only enroll as provided in the Special Enrollment or Open Enrollment Provisions of this Plan.

Employee's Signature_____

Employee's Name (please print)_____

Spouse Signature_____

Date_____

I hereby grant permission to TPSC or other service provider to release and receive any and all medical records, as permitted by law, for purposes of treatment, payment and healthcare operations for anyone making application, enrolled hereunder. I understand that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care. For more information about such disclosures, including uses and disclosures required by law, please refer to your plan document. A copy is available from the plan sponsor's web site or contact by phone.

I apply for enrollment for myself and the listed dependents and certify that (a) to the best of my knowledge, we are eligible for the coverage requested; (b) I have reviewed the product information and understand the exclusions, limitations, and waiting periods stated therein; and (c) all information on this form is true, correct, and complete. The changes on this form supersede all previous forms I have submitted. It is a crime to knowingly provide false, incomplete, or misleading information to an insurer or insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. I authorize my employer to deduct from my pay the amount, if any, to pay for the premiums for the coverage I have elected.

SUBSCRIBER'S SIGNATURE _____ **DATE** _____