Archdiocese of New Orleans, Group Number: 76-413717

2021/2022 BENEFIT ENROLLMENT/CHANGE FORM

Subgroup Number: _____ **Subgroup Name:**_____

Effective Date of Enrollment /Change: ___/___/_____

ENROLLMENT:	CHANGE:			TERMINATION DATE: _____
☐ Annual Enrollment	☐ Add/Remove Dependent	☐ Name Change	☐ Location Transfer from:_____ to: _____	☐ Termination of Employment
☐ New Staff Member	☐ Address Change	☐ "Family Status" Change	☐ Retiring: move from Class: _____ to Class: R001	☐ Death
☐ Rehired/Reinstatement	☐ Product Change from: _____ to: _____			☐ Layoff/Leave of Absence

SECTION A: STAFF MEMBER PERSONAL INFORMATION

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____ **SOCIAL SECURITY NO:** _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____ **HOME TELEPHONE:** _____ **CELL PHONE:** _____

DATE OF HIRE: _____ **GENDER:** ☐ FEMALE ☐ MALE **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ DIVORCED

SECTION B: MEDICAL BENEFIT PLANS - UMR (a United Healthcare Company)

☐ **CHECK HERE IF YOU ARE DECLINING MEDICAL COVERAGE**

I DECLINE TO ENROLL IN THIS COVERAGE DUE TO: ☐ Spouse's Group Employer Plan: Plan Name:_____; Policy Number: _____ ☐ Tri-Care ☐ Individual Plan ☐ Other:_____

☐ COBRA or other continuation coverage from Prior Employer ☐ Medicare ☐ Medicaid ☐ Retiree from Prior Employer ☐ VA Eligibility

MEDICAL PLAN 1 - HMO 90		MEDICAL PLAN 2 - HIGH DEDUCTIBLE HMO 80		MEDICAL PLAN 3 - POS		MEDICAL PLAN 4 - OUT OF AREA PPO PLAN	
(CHECK ONE)		(CHECK ONE)		(CHECK ONE)		(CHECK ONE)	
EE ONLY	☐	EE ONLY	☐	EE ONLY	☐	EE ONLY	☐
EE + SPOUSE	☐	EE + SPOUSE	☐	EE + SPOUSE	☐	EE + SPOUSE	☐
EE + CHILD(REN)	☐	EE + CHILD(REN)	☐	EE + CHILD(REN)	☐	EE + CHILD(REN)	☐
EE + FAMILY	☐	EE + FAMILY	☐	EE + FAMILY	☐	EE + FAMILY	☐

SECTION C: OTHER COVERAGE

Medical Plans: Dependent children are covered to age 26 regardless of student status.

Other Coverage Information: Will you or your dependents that you are enrolling in the plan have any other medical coverage in addition to this plan? ☐ Yes ☐ No

If yes, Please indicate carrier information:

Carrier Name:	Policy Number:	Group #	Coverage Start Date:	Coverage End Date:	Are you enrolled in Medicare?	☐ Yes	☐ No
					Medicare # _____	☐ Part A	☐ Part B

SECTION D: ELIGIBLE DEPENDENTS FOR MEDICAL PLANS (COMPLETE ONLY IF DEPENDENT COVERAGE IS ELECTED)

DEPENDENT NAMES (FULL NAME)	SSN	GENDER (Circle One)	DATE OF BIRTH	RELATIONSHIP	MEDICAL ADD/CANCEL Add/Cancel
SPOUSE:		M / F			☐ Add ☐ Cancel
CHILD 1:		M / F			☐ Add ☐ Cancel
CHILD 2:		M / F			☐ Add ☐ Cancel
CHILD 3:		M / F			☐ Add ☐ Cancel
CHILD 4:		M / F			☐ Add ☐ Cancel
CHILD 5:		M / F			☐ Add ☐ Cancel

HIPAA: If you are declining enrollment for yourself or your dependents because you have other group health coverage, you may in the future be able to enroll yourself and your dependents (Qualifying Event), provided that you request enrollment withing 30 days after your other coverage ends. 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 yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

See Other Side for Qualifying Events and Employee Acknowledgement

ARCHDIOCESE OF NEW ORLEANS

UMR
A UnitedHealthcare Company

Archdiocese of New Orleans, Group Number: 76-413717

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Employee Last Name:_____ **Employee First Name:** _____ **Subscriber #:**_____

SECTION E: QUALIFYING LIFE EVENT DATE:_____

☐ Marriage	☐ Placement for Adoption	If you lost coverage due to: (please complete Section C)	☐ Divorce	☐ Other:_____
☐ Birth	☐ Provisional Custody by Mandate		☐ Death	☐ COBRA or other continuation exhausted
☐ Adoption	☐ Qualified Medical Child Support Orde		☐ Termination or reduction in work hours	

SECTION F: STAFF MEMBER ACKNOWLEDGEMENT AND PREMIUM ONLY AUTHORIZATION - (AUTHORIZING DEDUCTIONS TO BE TAKEN ON A PRE-TAX BASIS)

I HEREBY UNDERSTAND THAT A SALARY REDUCTION FOR MEDICAL CONTRIBUTION PREMIUMS WILL BE TAKEN ON A PRE-TAX BASIS. I UNDERSTAND THAT THIS ELECTION CANNOT BE REVOKED DURING THE PLAN YEAR UNLESS THERE IS A QUALIFYING EVENT.

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.
Please refer to your Employee Benefit Booklet for specific detail of your benefit plan. I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

WAIVING COVERAGE:
Important: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes. If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPAA Special Enrollment because of loss of that coverage. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage:
I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage. For specific plan language contact your Human Resources Representative.
CERTIFICATION: I freely and voluntarily waive all coverage noted above.

_____ _____

Employee Acknowledgement (Signature Required) **Date:** **FORM LOADED INTO benefitsCONNECT ON:** _____