ARCHDIOCESE OF BALTIMORE HEALTH PLANS ENROLLMENT FORM

Please check one:
☐ New Hire ☐ Open Enrollment ☐ Change in Employment Status ☐ Change in Family Status (please attach documentation)

EMPLOYEE INFORMATION

Last Name – First Name – Middle Initial ____________________

Social Security Number ____________________

Home Address ____________________

City – State – Zip Code ____________________

Home Phone ____________________

Email ____________________

Direct Employer ____________________

Marital Status - ☐single ☐married ☐divorced ☐separated ☐widowed

PLAN SELECTION – SELECT PLAN AND COVERAGE LEVEL

Medical Plan

☐CIGNA OAP ☐Employee ☐Employee & Spouse
☐CIGNA PPO ☐Employee & Child ☐Family
☐No Coverage

Dental Plan

☐CIGNA ☐Employee ☐Employee & Spouse
☐UCCI ☐Employee & Child ☐Family
☐No Coverage

Vision Plan

☐VSP ☐Employee ☐Employee & Spouse
☐No Coverage ☐Employee & Child ☐Family

EMPLOYEE – DEPENDENT ENROLLMENT INFORMATION (*REQUIRED FIELDS)

			Yes/No	Please check all that apply
EMPLOYEE NAME	SEX*	DATE OF BIRTH*		☐Medical ☐Dental ☐Vision
SPOUSE NAME* & SOCIAL SECURITY NUMBER *	SEX*	DATE OF BIRTH*		☐Medical ☐Dental ☐Vision
DEPENDENT NAME* & SOCIAL SECURITY NUMBER*	SEX*	DATE OF BIRTH*	STUDENT*	☐Medical ☐Dental ☐Vision
DEPENDENT NAME* & SOCIAL SECURITY NUMBER*	SEX*	DATE OF BIRTH*	STUDENT*	☐Medical ☐Dental ☐Vision
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DEPENDENT NAME* & SOCIAL SECURITY NUMBER*	SEX*	DATE OF BIRTH*	STUDENT*	☐Medical ☐Dental ☐Vision
DEPENDENT NAME* & SOCIAL SECURITY NUMBER*	SEX*	DATE OF BIRTH*	STUDENT*	☐Medical ☐Dental ☐Vision

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United Concordia Dental Enrollment Only

Dentist ID #	current patient	Applies to:
		☐self ☐spouse ☐dependents
Dentist ID #	current patient	☐self ☐spouse ☐dependents
Dentist ID #	current patient	☐self ☐spouse ☐dependents

OTHER HEALTH INSURANCE INFORMATION (ONLY REQUIRED FOR THOSE ENROLLING IN A HEALTH PLAN)

FAILURE TO COMPLETE THIS SECTION WILL DELAY ENROLLMENT. Are you, your spouse, and/or dependent(s) currently covered for health care services with another health plan? ☐Yes ☐No If yes, provide the following :

Insurance Company	Policyholder Name	Effective Dates

FAILURE TO COMPLETE THIS SECTION WILL DELAY ENROLLMENT. Are you, your spouse, and/or dependent(s) currently covered for health care services with Medicare? ☐Yes ☐No If yes, provide the following:

Name & HICN	Name & HICN	Name & HICN

HICN – Health Insurance Claim Number found on Medicare ID Card

STATEMENT OF AUTHORIZATION

Medical/Dental: I certify that the above information is correct to the best of my knowledge and belief. I have elected the coverage(s) indicated above on behalf of myself and/or my eligible dependent(s) listed above. I authorize my direct employer to withhold any required premium from my salary through a pre-tax deduction. My direct employer has informed me of my cost for the coverage I have elected. I understand that I can only change or terminate my election at the beginning of the Plan Year, if my family status changes, or upon termination of employment. To all dentists, health professionals, and health care institutions: You are authorized to provide CIGNA, Caremark, United Concordia, VSP and any affiliated or independent claim administrators, consulting health professionals and utilization review organizations acting on CIGNA, Caremark, VSP or United Concordia's behalf or with whom these organizations have contracted, information concerning dental or other health care advice, treatment or supplies provided me or any members of my family now or hereafter covered under the Plans I have elected. This information will be used for the purposes of administration, review, investigation or evaluation of coverage claims and utilization of services under the Plans I have elected. CIGNA, Caremark, VSP or United Concordia may provide the Archdiocese of Baltimore with any benefit calculation(s) used in payment of my or our benefits under the Plans I have elected for the purpose of reviewing experience or operation of the program. The authorization is valid until the date my or our coverage under the Plans terminates. I know that I have the right to review a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

EMPLOYEE/APPLICANT SIGNATURE _____ DATE _____

WAIVER OF ALL HEALTH COVERAGE

(You only need to sign this section if you are waiving all health coverage.) I understand that I am entitled to enroll in one or more of the health plans offered through the Archdiocese of Baltimore. I have voluntarily chosen not to participate in ANY of the health plans. I understand that I can only join one of the health plans at the beginning of a new Plan Year or when there is a change in my family status that results in the loss of group health coverage. I also understand that I may be required to provide evidence of insurability if I enroll at a future date in order for coverage to be effective.

EMPLOYEE/APPLICANT SIGNATURE _____ DATE _____