# HEALTH CARE PLANS – ENROLLMENT/CHANGE FORM

Catholic Diocese of Cleveland • Employee Benefits Office
1404 East Ninth Street, Eighth Floor • Cleveland, Ohio 44114-1722
(216) 696-6525 or 621-3700 • Toll Free 1-800-869-6525 • Fax (216) 621-9622

EFFECTIVE DATE _____ *Complete and Return within 30 days of event*

EMPLOYER SECTION

## TO BE COMPLETED BY EMPLOYER –

Job Title _____ Hire Date _____

☐ Hourly ☐ Salaried Employee Class ... ☐ Active ☐ Retired

☐ Full Time .... Average Hours Per Year _____
Average Hours Per Week _____
☐ Part Time ... Average Hours Per Year _____
Average Hours Per Week _____

Authorized Signature _____ Date Signed _____

EMPLOYEE SECTION

## TO BE COMPLETED BY EMPLOYEE –

Name _____ Social Security Number _____
LAST FIRST M.I.

Address _____
NUMBER AND STREET APT. # CITY STATE ZIP CODE

Telephone No. _____ Email _____

Employer _____ Client No. _____

Date of Birth _____ Date of Hire _____ Sex ☐ Male ☐ Female _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Priest/Religious ☐ Widowed

Spouse's Full Name _____ Spouse's Social Security Number _____ Spouse's Date of Birth _____ Marriage Date _____

Spouse's Emp oyer _____ Employer's Address _____
NUMBER AND STREET CITY STATE ZIP CODE

## MEDICAL OPTION DESIRED (Select Plan Type and Coverage Level)

☐ MMO PPO/HSA
(High Deductible Plan with Health Savings)
☐ SuperMed PPO
☐ SkyCare EPO (MetroSelect)
☐ MedFlex EPO

☐ Single
☐ Family

***Required Documents for Dependents Enrolled in Medical Coverage***

**SPOUSE:** Working Spouse Verification Form, Marriage Certificate and Current Tax Return
**CHILDREN:** Birth Certificates

## METLIFE DENTAL (Select Plan Type and Coverage Level)

☐ Standard Dental
☐ PPO
☐ High Option PPO (extra cost)

Spouse Covered on Dental
☐ Yes
☐ No

☐ Single
☐ Family

## VISION SERVICE PLAN (OPTIONAL)

☐ Single
☐ Family

Spouse Covered on Vision
☐ Yes
☐ No

## ACTIVITY –

☐ New Participation
☐ Information Change
☐ Plan Change _____
☐ Loss of coverage under spouse's Group Medical Plan
☐ Coverage Level Status Change
☐ Other _____

## ADDITIONAL HEALTH INSURANCE PLAN - (Must Be Completed)

Do you or any family member have other coverage (including HMOs) for medical services? ☐ Yes ☐ No ..... ☐ Single Coverage ☐ Family Coverage

Name of Insured _____ Name of Insurance Company _____ Policy No. _____

| FULL NAME OF SPOUSE & DEPENDENTS TO BE COVERED | Relation | Male/Female | Date of Birth | Social Security No |
|---|---|---|---|---|
| *Spouse:* | | | | |
| *Child:* | | | | |
| *Child:* | | | | |
| *Child:* | | | | |
| *Child:* | | | | |

## FOR MEDICARE ELIGIBLES –

Complete this section if you are enrolled in the Federal Health Insurance Program administered by Social Security for enrollees 65 or older or disabled. NOTE: Active lay employees ages 65 and over (and spouses 65 and over) who have elected Medicare as their primary coverage are not eligible for Medicare Advantage coverage with the Catholic Diocese of Cleveland.

Are you enrolled in Hospital Insurance (Part A) Portion? ☐ No ☐ Yes Effective Date _____
Are you enrolled in Hospital Insurance (Part B) Portion? ☐ No ☐ Yes Effective Date _____
Medicare Claim No. _____

## YOUR SIGNATURE –

I authorize a deduction from my pay for health care coverage, if necessary for the options that I have chosen, in accordance with the standard schedule of charges in effect from time to time. I acknowledge receipt of copy of that schedule. I understand that Federal, State and Social Security (FICA) taxes are not withheld from my deduction, unless I have signed the Pretax Waiver Statement available from the Diocese Benefits Office. I further understand that by signing this form, I am making a binding election concerning my health care coverage for the Plan Year and that I may change my election only in accordance with Plan provisions. I certify that all information supplied on this form is true to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan terms. I agree to abide by the terms and conditions governing participation and receipt of health services in the options in which I have enrolled. I understand that falsification by me will allow the Catholic Diocese of Cleveland to recover payments made, cancel my coverage and or refuse to pay claims.

Signature of applicant _____ Date signed _____

**RETURN WITHIN 30 DAYS OF EFFECTIVE DATE**