



HEALTH CARE PLANS – MEDICARE ENROLLMENT/CHANGE FORM

Diocese of Cleveland • Employee Benefits Office
1404 East Ninth Street, Eighth Floor • Cleveland, Ohio 44114-1722
(216) 696-6525 x5040 • Toll Free (800) 869-6525 x5040 • Fax (216) 621-9622

Effective Date: _____

EMPLOYER SECTION

TO BE COMPLETED BY EMPLOYER —

Job Title _____ Hire Date _____

Authorized Signature _____ Date _____

PARTICIPANT SECTION

TO BE COMPLETED BY PARTICIPANT —

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

Address _____
NUMBER AND STREET CITY STATE ZIP CODE

Employer _____ Client # _____ Phone # _____

Birth Date _____ Sex Male Female

Single Married Divorced Separated Widowed Priest/Religious

PLAN DESIRED —

- Medical Mutual MedMutual Advantage PPO Plan *(includes prescription coverage)*
- MetLife dental coverage Standard PPO High Option PPO
- Vision Service Plan (VSP) coverage
- Cancel **ALL** coverage with the Catholic Diocese of Cleveland. **I UNDERSTAND THIS CANCELLATION IS FINAL.**

FOR MEDICARE ELIGIBLES —

Complete this section if you are enrolled in Medicare 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 supplemental coverage with the Catholic Diocese of Cleveland.

Are you enrolled in Hospital Insurance (Part A) Portion? No Yes Effective Date _____

Are you enrolled in Medical Insurance (Part B) Portion? No Yes Effective Date _____

Medicare Claim Number _____

Participant Notice of Plan Opt-Out Rights

Your Election to enroll in a MedMutual Advantage PPO plan as your retiree health benefit plan enrollment in will automatically cancel your enrollment in a different Medicare Advantage plan or a Medicare Prescription Drug plan. If you wish to opt out and not be enrolled in our plan, you have until your effective date, to contact Medical Mutual Member Services at (800) 982-3117, TTY 711, 8 a.m. to 8 p.m. seven days a week from October 1 to March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday and 9 a.m. to 1 p.m. Saturdays from April 1 through September 30 (except holidays).

You will need to keep Medicare Parts A and B as MedMutual Advantage is a Medicare Advantage Plan. You can be in only one Medicare Advantage Plan at a time. It is your responsibility to inform Medical Mutual of any prescription drug coverage that you have or may get in the future.

What happens if I don't join the MedMutual Advantage plan offered?

You aren't required to be enrolled in this plan. You can also decide to join a different Medicare plan. Call 1-800-MEDICARE for help in learning how. However, if you decide not to be enrolled, you will not have another plan option available through the Diocese. To opt out and request not to be enrolled by this process, please call the Medical Mutual Member Services at (800) 982-3117, TTY 711, 8 a.m. to 8 p.m. seven days a week from October 1 to March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday and 9 a.m. to 1 p.m. Saturdays from April 1 through September 30 (except holidays).

What if I want to leave the MedMutual Advantage plan offered?

You may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Medical Mutual. If you choose to leave the MedMutual Advantage plan at any time, you will not have the option to enroll again in the future.

YOUR SIGNATURE —

I am making a binding election concerning my coverage for the Plan Year and 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 will be provided in accordance with the Plan contract. I agree to abide by the terms and conditions governing membership and receipt of health services in the plan which I have enrolled. I understand that falsification by me will allow the Catholic Diocese of Cleveland to recover payments made, cancel my membership and/or refuse to pay claims.

Signature of Applicant _____ Date Signed _____