## ARCHDIOCESE OF BALTIMORE HEALTH PLANS ENROLLMENT FORM July 1, 2020 – June 30, 2021

(Coverage begins the first of the month following your date of hire or special enrollment right/qualified change in employment or family status change event (except for retroactive coverage effective on the date of birth or adoption of a child))

Please check or	ne:														
New Hire	Open Enrollment	Chan	ge in Eı	mployment Stat	us 🗌 Cha	nge in Far	nily Statı	us							
□a "	. 5				(Ple	ase attacl	n docum	entation)							
Special Enrollme	Special Enrollment Right														
EMPLOYEE INFORMATION															
Last Name, First Name, MI															
Street Address		Cit	City, State, Zip Code												
Home Phone			Em	Email											
Direct Employer			Ma	Marital Status - Single Married Divorced											
. ,			[	Legally Separated Widowed											
PLAN SELECTION – SELECT PLAN AND COVERAGE TIER															
	CIGNA Medical	CIGNA Me		CIGNA DENTAL	United Cond	noudio									
Tier of Coverage	OAP Plus	High Deduc		PPO	Dental Hi										
Individual	П	Health Plan (	(HDHP)												
Employee & Spouse															
Employee & Child**					<del>                                     </del>										
Family No Coverage															
	EMPLOYEE – D	<b>EPENDENT</b>	ENRO	DLLMENT INF	ORMATION	J									
Employee/Dependent Nan	ne		Sex	Date of Birth	Relationship	Medical	Dental	Vision*							
Same as above					Self										

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<sup>\*</sup>Included in medical; only select if not enrolling in medical or if tier of coverage is different (e.g., individual medical, family vision).

<sup>\*\*</sup>If enrolling more than one child, select Family coverage.

Are you, your spouse, and/or dependent(s) currently covered for health care services with another health plan that will continue past you benefit effective date?    Yes	For United Concordia Dental HI															
The content of the						II specio										
Yes	Defitist ID #	Cuii	$\overline{}$		$\overline{}$	0	Appi	$\overline{}$				Spouse		Г	Dependents	
OTHER HEALTH INSURANCE INFORMATION (Only required for employees enrolling in a health plan whose other insurance will continue past benefit effective date.)  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 that will continue past you benefit effective date?    Yes   No			=			0		=				<del>-</del>		Ē	1	
Contyrequired for employees enrolling in a health plan whose other insurance will continue past benefit effective date.]			Y	'es	N	0			Self			Spouse			Dependents	
Are you, your spouse, and/or dependent(s) currently covered for health care services with another health plan that will continue past you benefit effective date?    Yes	(Only required for em												it effect	tive o	date.)	
Insurance Company  Policyholder Name  Effective Dates  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*  Nam	Are you, your spouse, and/or dep			curi	rentl	<u>cove</u>	red for		th care s				ealth	plaı	n that will continue	past you
Are you, your spouse and/or dependent(s) currently covered for health care services with Medicare?    Yes				-					if yes, p	rovide	e th	_				٦
Name & HICN*  Na	Insurance Company			P	Olicy	noide	er Nam	e				Effective	Dates	5		
**HICN - Health Insurance Claim Number found on Medicare ID Card  **STATEMENT OF AUTHORIZATION  **Locarity 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 abunderstand that the above elections will remain in effect until the last day of the Period of Coverage (i.e., the Plan Year) noted above and will continue in effect indefinitely beyond the Period of Coverage noted above unless in make an election shape in the period of Coverage (i.e., the Plan Year) noted above and will continue in effect indefinitely beyond the Period of Coverage (i.e., the Plan Year) noted above and will continue in effect indefinitely beyond the Period of Coverage (i.e., the Plan Year) noted above and will continue in effect indefinitely beyond the Period of Coverage (i.e., the Plan Year) noted above and will continue in effect indefinitely beyond the Period of Coverage (i.e., the Plan Year) noted above and will continue in effect on the Period of Coverage (i.e., the Plan Year) noted above and will continue in effect on the Plan Year) noted and year of the Coverage (i.e., the Plan Year) noted and year of the Coverage (i.e., the Plan Year) noted and year of the Coverage (i.e., the Plan Year) noted and year of the Plan Year) noted and year of the Coverage (i.e., the Plan Year) noted and year of the Coverage (i.e., the Plan Year) noted and year of the Coverage (i.e., the Plan Year) noted and year of the Plan Year) noted and year of the Coverage (i.e., the Plan Year) noted and year of the Coverage (i.e., the Plan Year) noted and year of the Plan Year) noted and year of the Plan Year of Year Plan Year (i.e., the Plan Year) noted and year of Year Plan Year (i.e., the Plan Year) noted and year of Year Plan Year (i.e., the Plan Year) noted and year of Year Plan Year (i.e., the Plan Year) note year of Year Year (i.e., the Plan Year) note year of Year Year (i.e., the Plan Year) noted year of Year Year (i.e., the Y	Are you, your spouse and/or dep	ender	nt(s)		_		ed for						•			_
*HICN — Health Insurance Claim Number found on Medicare ID Card  STATEMENT OF AUTHORIZATION  Leartify that the above information is correct to the best of my knowledge and belief. I have elected the coverage (i) indicated above on behalf of myself and/or my eligible dependent(s) listed abounderstand that the above electron shape need electron change permitted under the Para, or until the date my or our coverage under the Para is emission, in electron change permitted under the Para, or until the date my or our coverage under the Para is emission, in electron change permitted under the Para, or until the date my or our coverage under the Para is emission, in electron change in the permitted of the properties of the properties of the properties by submitting in the Para of the properties of the								i	if yes, pro	vide t	he	following:				=
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understand that the above elections will remain in effect until the last day of the Period of Coverage (i.e., the Plan Year) noted above and will continue in effect indefinitely beyond the Period of Coverage by above unless I make an election change permitted under the Plan, or until the date my or our coverage under the Plans terminates. Inderstand that I may change the above elect for a future Period of Coverage by submitting a new Errollment Form during a later annual election period, or if I experience a special errollment right, qualified status change event, termination employment, or so therwise permitted under the Plan. I authorize my direct employer to withhold any required permitmy my salary through a per-tax deduction. My direct employer has informed me of my cost for the coverage I have elected. I understand that the cost of a benefit option that I have elected under the Plan may change from one Period of Coverage to the next and hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Enrollment Form during a perporpate annual election period to change or terminate that coverage. I also understand that, during a Period of Coverage, if there is a change in the cost of a benefit option that I have elected, my employer may automatically increase or decrease the among opayroll deductions a mere quired to make per pay period to pay for that benefit option. I understand further that, except exent an amenitated to make an election change under the Plan the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options. I have been dependent to expend the method of the method of the propose of administration, review, investigation or evaluation of coverage class of my family now of the propose of administration, review, invest					STA	TEM	ENT C	F A	UTHOR	IZAT	OI	N				
WAIVER OF ALL HEALTH COVERAGE Only 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 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 (July 1) or at the time experience a qualified life event.	of payroll deductions I am required to make per the payroll deduction elections I have made abd dentists, health professionals, and health care I health professionals and utilization review orga dental or other health care advice, treatment o purposes of administration, review, investigation the Archdiocese of Baltimore with any benefit of I know that I have the right to review a copy of I understand that my employer may modify my requirements) of applicable law and that, subje benefit option. Also, I understand that my emp provide health coverage for a dependent.	r pay per ove will on institution institution in supplie in or evaluation this auth benefit ct to the loyer man	riod to contino ons: You is actir es provaluation on(s) un election e requi ay mo	p pay for ue in early are a go on Cyided ron of consisted in consisted in consisted in the consistency on sife a greener dify m	or that effect in author CIGNA, me or a overage in paymoon rece appropents of a by elect	benefit of otwithst zed to p Caremar ny mem e claims ent of my uest and riate to i pplicable ions for other to be to be to be to be	option. I u anding am rovide CIG k, United (bers of my and utilizar or our bed agree that a law or an acertain hea	nderst y chan; NA, Ca Concor family tion of nefits t a pho the Pl y appli ilth be	and further to ges in the feat remark, Unit dia or VSP's y now or here services und under the Pla otographic co an complies icable insural nefit options	that, exc atures or ded Conc behalf or eafter co er the P ans I hav opy of th with the nce cont if requir	ept to cover or with the cover or with the cover of the c	to the extent I am perage offered under a, VSP and any affilith whom these organism I have elected. Cloected for the purposition is as vans of the Plan and 1, my employer reta o do so by a Qualifederal tax purpose	permitte ar the be iated or anization have elected as the requires the requires the right matter than the requires the right matter than the results. I also	d to renefit indepose have ected emar viewire originate to continue to continu	make an election change un options I have elected above opendent claim administrato ve contracted, information of I. This information will be unk, United Concordia or VSP and experience or operation ginal.  Lents (including tax-qualification amend or terminate coverable that require that the coverage of the coverage	der the Plan re. To all rs, consultin sconcerning sed for the may provide of the progra tion rage under a uires me to
WAIVER OF ALL HEALTH COVERAGE  Only 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 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 (July 1) or at the time experience a qualified life event.	employer may also require proof that my deper					_	-								•	
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