ARCHDIOCESE OF BALTIMORE HEALTH PLANS ENROLLMENT FORM

(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 one: (Please attach documentation)

☐ New Hire ☐ Open Enrollment ☐ Change in Employment Status ☐ Change in Family Status
☐ Enroll ☐ Terminate
☐ Special Enrollment Right

EMPLOYEE INFORMATION

Last Name, First Name, MI	**SSN**
Street Address	**City, State, Zip Code**
Home Phone	**Email**
Direct Employer	**Marital Status -** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed**

PLAN SELECTION – SELECT PLAN AND COVERAGE TIER

Tier of Coverage	CIGNA Medical OAP Plus	CIGNA Medical High Deductible Health Plan (HDHP)	CIGNA DENTAL PPO	*United Concordia Dental HMO (Frozen Plan)	Cigna Standalone Vision
Individual	☐	☐	☐	☐	☐
Employee & Spouse	☐	☐	☐	☐	☐
Employee & Child**	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐
No Coverage	☐	☐	☐	☐	☐

EMPLOYEE – DEPENDENT ENROLLMENT INFORMATION

Employee/Dependent Name	SSN	Sex	Date of Birth	Relationship	Medical	Dental	Vision
Same as above				Self	☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

***If enrolling more than one child, select Family coverage.*

*** No new enrollments accepted, only changes to current UCCI plan participants.*

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 your benefit effective date? ☐ Yes ☐ No if yes, provide the following:

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*	Name & HICN*	Name & HICN*

*HICN – Health Insurance Claim Number found on Medicare ID Card

STATEMENT OF AUTHORIZATION

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 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 noted above unless I make an election change permitted under the Plan, or until the date my or our coverage under the Plans terminates. I understand that I may change the above elections for a future Period of Coverage by submitting a new Enrollment Form during a later annual election period, or if I experience a special enrollment right, qualified status change event, termination of employment, or as otherwise permitted under the Plan. 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 the cost of a benefit option that I have elected under the Plan may change from one Period of Coverage to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Enrollment Form during the appropriate 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 amount of payroll deductions I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent I am permitted 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 elected above. To all dentists, health professionals, and health care institutions: You are authorized to provide CIGNA, United Concordia, and any affiliated or independent claim administrators, consulting health professionals and utilization review organizations acting on CIGNA, 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 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. 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.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that my employer may modify my elections for certain health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

I understand that I am responsible for determining if my dependent is eligible to be treated as my spouse or dependent for federal tax purposes. I also certify that any person for whom I am electing dependent coverage meets the applicable requirements for dependent coverage and I agree to inform my employer if that changes while my election of coverage is in effect. I understand that my employer may also require proof that my dependent meets the Plan's dependent eligibility requirements and that my employer retains the ultimate authority to determine any person's eligibility for coverage.

EMPLOYEE/APPLICANT SIGNATURE	DATE

WAIVER OF ALL HEALTH COVERAGE

Only sign this section if you are waiving <u>all</u> 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 (July 1) or at the time I experience a qualified life event.

EMPLOYEE/APPLICANT SIGNATURE	DATE