



HEALTH CARE PLANS – ENROLLMENT/CHANGE FORM

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 _____

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 _____

TO BE COMPLETED BY EMPLOYEE –

Name _____ Social Security Number _____

LAST FIRST MI

Address _____ CITY STATE ZIP CODE

NUMBER AND STREET

Employer _____ Client No. _____ Telephone No. _____

WORK HOME

Date of Birth _____ Date of Hire _____ Sex Male Female

Single Married Divorced Separated Priest/Religious Widowed

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

Spouse's Employer _____

Employer's Address _____ CITY STATE ZIP CODE

NUMBER AND STREET

MEDICAL PLAN DESIRED (Select Plan Type and Coverage Level)

SuperMed PPO Kaiser Permanente Single

SuperMed HMO _____ Family

(Must List Primary Care Physician) Medicare Supplement

METLIFE DENTAL (Select Plan Type and Coverage Level)

Standard Dental PPO High Option PPO (extra cost)

VISION SERVICE PLAN (OPTIONAL)

Single Family

ACTIVITY –

New Participation Plan Change _____ Coverage Level Status Change

Information Change Loss of coverage under spouse's Group Medical Plan 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. _____

Insurance Company Address _____ CITY STATE ZIP CODE

NUMBER AND STREET

FULL NAME OF SPOUSE & DEPENDENTS TO BE COVERED

Relation	Male/Female	Date of Birth	Social Security No

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 supplemental coverage with the Catholic Diocese of Cleveland.

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

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

YOUR SIGNATURE –

I authorize a deduction from my pay for medical coverage, if necessary for the plan 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 medical 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 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 _____

EMPLOYEE SECTION