Archdiocese of St. Louis Health Insurance

Employee Enrollment/Change/Cancellation Request Form

Please check applicable box(es):

- ☐ Enroll
- ☐ Cancel
- ☐ Change
- ☐ Waive
- ☐ Address Change
- ☐ Name Change
- ☐ Beneficiary Change
- ☐ Effective Date of Action:

Employer Information (to be completed by the employer)

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records. Keep a copy in the employee medical file. **Please fax the completed form to 314.792.7548 or mail to Office of Human Resources, 20 Archbishop May Drive, St. Louis, MO 63119 to process the application.**

Parish / School / Agency Name	Employer Benefit Invoice #

☐ **New Enrollment/Additions/Changes:** (Check One)
Date of Hire:
(required for new coverage)
- ☐ New Hire ☐ Status Change (ex: PT to FT)
- ☐ Location Transfer From:
- ☐ Add Spouse or Dependents:
- ☐ Birth ☐ Marriage ☐ Adoption ☐ Court ordered
- ☐ Continuation of Coverage Plan:
  maximum # of months: ☐ 18 ☐ 29 ☐ 36
- ☐ Early Retiree Plan
- ☐ Other (describe):

☐ **Cancellations:** (Check One)
Last Date of Employment:
(if applicable)
- ☐ Cancel coverage(s)

Reason for Qualifying Event:
- ☐ Death ☐ Employee Terminated ☐ Divorce
- ☐ Medicare eligible
- ☐ Dependent reached dependent maximum age
- ☐ Cancel Spouse or Dependent(s) coverage only
- ☐ Location transfer: To:
- ☐ Other (describe):

Employee Status: (Check one) ☐ Full Time ☐ Part Time

Employee Pay Frequency: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

Employer Signature:	Date:	Employer Position/Title:

Phone Number:	Employer Email Address:

Sections A – F to be completed by the employee

A. Employee Information

Last Name:	First Name:	MI:	Social Security Number:

Address:	Apt #:	City:	State:	Zip Code:

Home/Cell Phone:	Work Phone:	Email Address:

Date of Birth:

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who Should be Covered: (Check one)
- ☐ Employee Only
- ☐ Employee Plus One (Spouse or Child)
- ☐ Employee Plus Family

Health Plan: (Check one)
UHC Choice Plus: Group # 703597
- ☐ Standard Plan
- ☐ Premier Plan

This form automatically enrolls/changes/cancels you and your dependent(s) for the following:
- Medical and Prescription coverage provided by UnitedHealthcare.
- Dental coverage provided by Delta Dental of Missouri.
- Life insurance coverage provided by Unum Life Insurance Company.

B. Employee Family Information (List all Enrolling/Changing/Cancelling – attach addtl. sheet if necessary)

Check Appropriate Box	Last Name First Name MI Social Security Number	Sex	Relationship	Date of Birth	Other Insurance: Yes	No
☐ Enroll ☐ Cancel		M ☐ F ☐	Spouse		☐	☐
☐ Enroll ☐ Cancel		M ☐ F ☐	Dependent		☐	☐
☐ Enroll ☐ Cancel		M ☐ F ☐	Dependent		☐	☐
☐ Enroll ☐ Cancel		M ☐ F ☐	Dependent		☐	☐
☐ Enroll ☐ Cancel		M ☐ F ☐	Dependent		☐	☐

C. Coverage Change Due To Qualifying Event

You are eligible to change your coverage only when you experience one of the qualifying events listed below. The coverage change must directly relate to the qualifying event and must be requested within 31 days after the event occurs. Please indicate the applicable event below and fill in the date of the event.

Event	Documents Required to Terminate from the Plan	Documents Required to Enroll in the Plan	Date of Event
☐ Marriage	No Document Required	Marriage Certificate	
☐ Divorce/Legal Separation	Divorce Decree/Legal Separation Agreement	Divorce Decree/Legal Separation Agreement	
☐ Death of Spouse/Dependent	No Document Required	No Document Required	
☐ Birth of Child	No Document Required	No Document Required	
☐ Legal Adoption/Placement in Employee's Home	No Document Required	Legal Adoption Papers/ Letter of Placement	
☐ Dependent reaching 26 years of age	No Document Required	No Document Required	
☐ Employee/Dependent Status Change	No Document Required	No Document Required	
☐ Spouse/Dependent begins new job	No Document Required	No Document Required	
☐ Spouse's or Dependent's Loss of Coverage/or currently enrolled in other Cobra Plan	No Document Required	Certificate of Creditable Coverage from previous insurance	
☐ Spouse's or Dependent's Open Enrollment	No Document Required	Open Enrollment Information	
☐ Court Order, Judgment, or Decree	No Document Required	Court Order Agreement	
☐ Significant Coverage Decrease	No Document Required	No Document Required	
☐ Significant Cost Change > 10%	No Document Required	No Document Required	

If a new dependent relationship forms as the result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after such event. I understand that I am limited as to when I may drop coverage under this plan: during open enrollment, and upon a qualified status event. I certify, if applicable, that the dependent(s) listed above are truly eligible, as written in the health insurance Plan document. I confirm that the information I have provided on this form is complete and accurate.

D. $10,000 Term Life Insurance Beneficiary Information

A $10,000 term life insurance is included with the Archdiocesan Health Insurance Plan. The coverage drops to $5,000 at age 70. It is important that your beneficiary designation be clear so that there will be no question as to your meaning. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth, and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

Full Name	Full Address	Social Security #	Relationship	Date of Birth	%
Primary Beneficiary					
Contingent Beneficiary					

E. Waiver of Employee Health Insurance Coverage

I decline coverage for: ☐ Myself ☐ Spouse ☐ Dependent Children ☐ Myself and all dependents

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials:	Date:

F. Signature

Authorization/Release of Information:

On behalf of myself and anyone enrolled on, or added to this form, I authorize my employer to deduct my contributions toward the cost of this coverage from my salary. I further authorize release of information pertaining to medical history or services rendered, or for any analytical or research purposes, from any physician, medical practitioner, hospital, and clinic, other medical or medically related facility, insurance or reinsurance company, employer or third party administrator. I understand that information used under this authorization may be used to determine eligibility for coverage and benefits for my dependents and me and that such information may be released to persons or organizations performing business or services in connection with the processing of any claims submitted under this plan.

Notice of Enrollment Rights:

I understand that if I and/or my dependents (if any) waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after such coverage ends.

Dependent Attestation:

I certify that the documentation provided is true and correct and meets the Definition of Eligible Dependents eligibility requirements. I understand that the falsification of documents or covering of ineligible dependents may result in termination of coverage.

Employee Signature:	Date:	Email Address:

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.