

Diocese of Palm Beach Medical and Dental Enrollment Form

Please complete the next section for you and your eligible dependents applying for medical or dental coverage.
(If more space is needed, please attach a separate sheet with additional info)

Name	Social Security Number	Birth date mm/dd/yy	Sex (Circle)	Relationship to Employee Spouse (SP) Child(CH) Self	Medical	Dental
Self			M F		Yes No	Yes No
Spouse			M F		Yes No	Yes No
Dependent 1 <input type="checkbox"/> Disabled <input type="checkbox"/> Supported by you <input type="checkbox"/> Living with you <input type="checkbox"/> FT/PT Student			M F		Yes No	Yes No
Dependent 2 <input type="checkbox"/> Disabled <input type="checkbox"/> Supported by you <input type="checkbox"/> Living with you <input type="checkbox"/> FT/PT Student			M F		Yes No	Yes No
Dependent 3 <input type="checkbox"/> Disabled <input type="checkbox"/> Supported by you <input type="checkbox"/> Living with you <input type="checkbox"/> FT/PT Student			M F		Yes No	Yes No

3. OTHER CARRIER LIABILITY INFORMATION – THIS SECTION MUST BE COMPLETED

On the day your coverage begins, will you or any family members enrolling in this plan be covered by any other group or individual health insurance or Medicare?
___ Yes ___ No **If yes, fill out the appropriate section(s) below. If more space is required, attach a separate sheet with additional information.**

Health		Additional Health		Medicare		Medicare	
Insured's/Members Name	Date of Birth	Insured's/Members Name	Date of Birth	Beneficiary Name	Beneficiary Name	Beneficiary Name	Beneficiary Name
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Name of Employer	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Name of Employer	Entitlement Reason <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal <input type="checkbox"/> Disease <input type="checkbox"/> Other Disability	Entitlement Reason <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal <input type="checkbox"/> Disease <input type="checkbox"/> Other Disability	Entitlement Reason <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal <input type="checkbox"/> Disease <input type="checkbox"/> Other Disability	Entitlement Reason <input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal <input type="checkbox"/> Disease <input type="checkbox"/> Other Disability
Policy #	Effective Date	Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Policy #	Effective Date	Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Medicare HIC Number	Medicare HIC Number
Name of Insurance Company	Phone #	Name of Insurance Company	Phone #	Part A Effective Date	Part A Effective date	Part B Effective Date	Part B Effective Date
City, State and Zip Code of Claims Center		City, State and Zip Code of Claims Center					
Does the above insurance cover "all" family members including yourself? Yes ___ No ___ If no, please list the names of all dependents not covered:		Does the above insurance cover "all" family members including yourself? Yes ___ No ___ If no, please list the names of all dependents not covered:					

4. PRIOR COVERAGE CERTIFICATION (see page 3)

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PRIOR COVERAGE CERTIFICATION

Complete the following only if this is the first time you or your dependents : (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have had any health coverage in the past 12 months that this coverage replaces.

Health Carrier Name _____ Contract Number _____

Effective Date _____ Prior Employee Hire Date _____ Cancel Date _____

Reason _____

State full names of all family members that were covered, including yourself. *Attach separate sheet if needed, sign and date.*

5. EMPLOYEE'S AGREEMENT

By signing below, I understand that if I am eligible for benefits, the elections I make will remain in effect throughout the policy year unless I have a qualifying change in family status, or my employment status changes (e.g., termination of employment, disability, work schedule changes, etc.). I also understand that I am required to make contributions for benefits as applicable. I certify that my answers to the questions on this form are complete and honest and may be relied upon by the Program Administrator(s) in its entirety.

Employee's Signature

Date: _____

EMPLOYER VALIDATION

The above section must be completed in its entirety before submission by the employer to the Benefits Office. The employer's deadline to return all forms is within 30 days from the effective date of employment. This form will not be processed unless all the appropriate information and necessary signatures are provided.

AGENCY: **Diocese of Palm Beach Benefits Office**

Authorized Signature: _____

Date: _____

Acceptance of Coverage or Change Authorization

Plan Coverage Terms

I hereby apply for coverage/membership or authorize the changes to my Blue Cross Blue Shield of Florida, Inc. (BCBSF) and Delta Dental as is selected on this form. I understand that coverage/membership or changes will not be effective until this application is accepted by BCBSF and Delta Dental.

I authorize my employer to deduct from my earnings, my premium contribution, if any. I understand I am responsible for all missed deductions as well as:

1. If my coverage is to be issued and continued or changed, I must meet all the group contract's requirements;
2. If my dependent's coverage/membership, if any, is to be issued and continued, my dependents must meet all of the group contract's requirements.
3. If I must pay part or all of the premium, coverage/membership shall not become effective until BCBSF and/or Delta Dental accept this application and assigns an effective date.

I understand that membership granted to persons herein shall be subject to all provisions and limitations of the group contracts. I am aware that a change in coverage of dependents may affect the amount deducted from any wages (if any) for coverage/membership and I hereby authorize such a change.

I understand that a dependent cannot be: (1) covered as both a dependent and an employee, including married employees of the same employer or (2) covered under more than one employee.

General Terms

I AGREE that in the event of any controversy or dispute with BCBSF and/or Delta Dental my dependents and I must exhaust the appeal and/or grievance processes in the benefit/member handbook issued to me.

I understand that my employer is not an agent of BCBSF or Delta Dental. I also understand that my employer is responsible for notifying all employees of:

1. Effective dates;
2. All termination dates;
3. Any conversion, COBRA, or ERISA rights or responsibilities; and
4. All other matters pertaining to coverage under the group contract.

When an overpayment is made, I authorize BCBSF and/or Delta Dental to recover the excess from any person or entity that received it.

I acknowledge that BCBSF and/or Delta Dental coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for BCBSF and/or Delta Dental coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period. I acknowledge that any applicable credit toward a health care Pre-Existing Condition Exclusion Period is contingent upon the complete and accurate disclosure of information.

I represent that the statements on this application are true and complete to the best of my knowledge and belief.

I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions.

Acceptance of Health Coverage/Change Authorization for Health Coverage

I have read, understand, and agree to the Acceptance of Health Coverage/Change Authorization terms on this form.

FRAUD NOTICE: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee Signature:

Date:

Employer Signature:

Date: