Roman Catholic Diocese of Gary

Group Number : ______________________

Enrollment Form

EMPLOYEE INFORMATION. Please verify the information below for accuracy. If incorrect, please contact your HR representative.

Name/Address	Date of Birth	Employee ID/SSN
______________________	Division	Date of Hire
______________________		
______________________	BillClass	SubGroup
	Effective Date	Gender

PLEASE PRINT IN BLACK OR BLUE INK. Read and complete all of this form. Please complete all sections. If you need more space, attach a separate sheet of paper. Please use four digits for years (e.g. 1998, not 98).

Are you actively at work? Yes ☐ No ☐
Are you retired? Yes ☐ No ☐
Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐
Occupation: ______________________
Phone: ______________________
Hours per week working for this employer: ________ **Email Address:** ______________________

BENEFIT SELECTION. Check the boxes that apply along with the appropriate coverage level.

Voluntary Dental
Low Option

Regular dental check-ups can help in the detection of other health related issues. Gum and tooth disease have been linked to major health conditions like heart disease and stroke. That's why dental coverage is more important than ever.

Accept ☐ **Decline** ☐

	Coverage Level	Monthly Premium
☐	Employee Only	$19.83
☐	Employee + One	$39.68
☐	Family	$51.58

Voluntary Dental High Option	Regular dental check-ups can help in the detection of other health related issues. Gum and tooth disease have been linked to major health conditions like heart disease and stroke. That's why dental coverage is more important than ever.

Accept ☐ Decline ☐

	Coverage Level	Monthly Premium
☐	Employee Only	$30.18
☐	Employee + One	$59.25
☐	Family	$90.54

Voluntary Vision	Consider how important good vision is to everyday activities like driving, shopping or watching a movie. Taking care of your vision is essential to your overall health and well-being. Did you know that having regular eye exams can reduce the risk of more serious, long-term diseases?

Accept ☐ Decline ☐

	Coverage Level	Monthly Premium
☐	Employee Only	$6.83
☐	Employee + Spouse	$13.24
☐	Employee + Child(ren)	$13.86
☐	Family	$21.35

DEPENDENT DESIGNATION

(Complete all details for individuals applying for coverage: list names of all dependents.)

Last name, First name, M.I.	SSN (XXX-XX-XXXX)	Sex	Date of Birth (XX-XX-XXXX)	Age	Relationship (spouse/ or child)
	- -	☐ M ☐ F	/ /		Spouse
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child

List address of all dependents if different from the applicant, including temporary address, e.g. college student.

Name/Address: ______________________ / ____________________________________

Name/Address: ______________________ / ____________________________________

ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

My signature certifies that I (1) Apply for the coverages designated for which I am eligible under my employer's plan with the carrier. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health to the carrier. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature ______________________________ Date ________/________/________

Premium calculations above may differ slightly based on rounding rules and other system factors, but will not vary significantly. Every effort has been made to match your premiums to the penny.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

Anthem Blue Cross and Blue Shield is the trade name of: Anthem Insurance Companies, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.