MERITAIN HEALTH
An Aetna Company

EMPLOYEE ENROLLMENT/CHANGE FORM

THE ROMAN CATHOLIC ARCHDIOCESE OF ATLANTA

APPLICATION BEING MADE FOR: HEALTH PLAN

(Check One):

- ○ EMPLOYEE COVERAGE
- ○ EMPLOYEE + SPOUSE COVERAGE
- ○ EMPLOYEE + CHILD(REN) COVERAGE
- ○ EMPLOYEE + FAMILY COVERAGE

Plan Option Selection:

- ○ Value Plan
- ○ Premier Plan

For completion by employer:

Application being made for:

- ○ New employee coverage
- ○ Special enrollee (attach proof)
- ○ Late enrollee/open enrollment

EMPLOYEE NAME - LAST, FIRST, MIDDLE INITIAL	DATE OF BIRTH (type)	**SEX** MALE ○ FEMALE ○	SOCIAL SECURITY NO.

HOME ADDRESS	CITY	STATE	ZIP CODE	AREA CODE PHONE NUMBER
SPOUSE ADDRESS (if different)	CITY	STATE	ZIP CODE	AREA CODE PHONE NUMBER

MARITAL STATUS	DIVISION (Select One)
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Date:	☐ 01 - PRIESTS ☐ 02 - LAY ☐ 03 – SEMINARIANS ☐ 04 - RELIGIOUS

EMPLOYER:	LOCATION NAME	EMAIL ADDRESS (optional)
Roman Catholic Archdiocese of Atlanta		

If you are adding a dependent, you may need to provide additional documentation to prove their eligibility.

PRINT NAMES OF DEPENDENTS APPLYING FOR COVERAGE: (LAST, FIRST) **(LIST THE NAME OF EVERY DEPENDENT THAT WILL BE COVERED)**	SOCIAL SECURITY NUMBER	LEGAL RELATIONSHIP: SPOUSE, CHILD, STEP-CHILD, ETC	GENDER: (M / F)	DATE OF BIRTH MO DAY YR

I hereby authorize any health plan, provider of health care services or their Business Associates who have any records, knowledge, or Protected Health Information of me or any family member for whom coverage is requested, to share the information with Corporate Benefit Services of America, Inc., and its Business Associates who provide services for the health plan described herein, for the purposes of determining eligibility for enrollment or underwriting for me and for my family members for the health plan. A photographic copy of this authorization shall be as valid as the original.

I hereby request the amount(s) and Benefits for which I am or may become eligible and hereby authorize my employer to deduct the required contributions, if any, from my earnings.

I certify that the information I have set forth in this application is true and correct to the best of my knowledge. No information has been knowingly withheld or omitted concerning me or my dependents. I understand that providing false information in this application is a crime and may result in the denial of claims or cancellation of coverage. In addition I may be subject to civil and/or criminal penalties.

X_____ _____

Sign your name, DO NOT PRINT OR TYPE — Date

Providing the above authorization makes it possible to determine your eligibility for enrollment in this health plan. As described in the Notice of Privacy Practices, you may revoke this authorization at any time as provided by applicable law and except to the extent that this authorization has been relied upon.

FOR EMPLOYER USE ONLY/EMPLOYEE BENEFITS OFFICE:

DIVISION # _____ LOCATION # _____ DATE OF FULL TIME EMPLOYMENT _____

EFFECTIVE DATE OF CHANGE / COVERAGE _____ ORIGINAL PART TIME HIRE DATE _____

WHAT IS THE MINIMUM NUMBER OF HOURS WORKED PER WEEK? _____

Comments: _____

FOR MERITAIN HEALTH USE ONLY:

☐ Timely	Prior Plan Credits	
☐ Late	Wait Start	Group Number 10974
☐ Special	Cert Start _____	Effective Date
☐ New	Cert End	Account Rep

LF _____ MD _____ DI _____ DN_____DL_____OTH _____VS _____24 _____SAL _____LTD _____PPO _____

DEPT _____ LIFE2 _____ CV SUFFIX _____COMMENTS:_____ RETURN TO REP: _____

OTHER COVERAGE INFORMATION

This information you provide about other coverage will be used to coordinate benefits with any other group health plan you may have.
Please provide the month, day and year for effective dates of coverage.

1. Will your dependents continue to be covered under another health insurance or dental plan while covered by this plan?
   Medical ❑ Yes ❑ No Dental ❑ Yes ❑ No
   If yes, please answer the following:
   a. Name of policy holder _____ Date of birth _____
   b. If this coverage is through your spouse's employer, please list the employer's name: _____
   c. If this is not through an employer, please list the source of other coverage: _____
   Name of medical insurance company_____ Telephone number _____
   Name of dental insurance company _____ Telephone number _____
   d. Who will continue to be covered: ❑ Spouse ❑ Children
   List names of covered persons:_____
   e. Effective date of medical policy _____ Type of plan: ❑ Group ❑ Individual ❑ COBRA ❑ Other
   f. Term date of medical policy _____
   g. Effective date of dental policy _____ Type of plan: ❑ Group ❑ Individual ❑ COBRA ❑ Other
   h. Term date of dental policy _____

MEDICARE INFORMATION

1. Do your dependents currently have Medicare coverage? ❑ Yes ❑ No
   (If yes, please answer the following:)
a. If you or your spouse are retired, please supply the retirement date(s) _____
b. Name of person covered by Medicare _____ Medicare claim number _____
c. Medicare eligibility is due to: ❑ Overage 65 ❑ End-stage renal disease ❑ Total Disability
d. Part A effective date _____ Part B effective date _____

OTHER COVERAGE

1. Is there other coverage for your children due to a court decree? ❑ Yes ❑ No
   If yes, name of parent(s) with legal custody of children: _____
   Address of parent(s) with legal custody: _____

   Is there a court order making the non-custodial parent responsible for the child(ren)'s medical/dental expenses? ❑ Yes ❑ No
   If yes, please supply a copy of the legal documentation for this decision.
   Failure to provide this information will result in denial of claims submitted for you or your family members.

DECLINATION OF ENROLLMENT IMPORTANT!

If you are waiving your dependents' right to coverage under this plan, you must declare the reason for declination in writing below. Failure to declare your reasons for waiving coverage may limit your opportunity to join the plan later.

If you are declining enrollment for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

I have been given the opportunity to participate in the benefit plan, but after due consideration, I have elected not to participate in each of the categories checked below:

Effective Date of Declination _____ ☐ SPOUSE ☐ CHILD(REN)

List names of dependents to be declined: _____

REASON FOR REFUSAL OF MEDICAL COVERAGE:

☐ Have coverage under another plan. Name of Other Plan _____

Indicate who is currently covered under other plan(s): ☐ Spouse ☐ Children

☐ Other. Give Explanation _____

I understand that failure to specify that I am declining coverage because my spouse and/or children have other coverage may waive my special enrollment rights as described above. I further understand that by not applying for the coverage above, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information. Penalties such as deferred effective dates may be imposed. I hereby certify that I am declining coverage for the dependents indicated above because such dependents are currently covered under the plan(s) named above, and that this information is true and correct to the best of my knowledge. I understand that if I have provided false information regarding the coverage of my dependents under other plan(s) that I may be subject to adverse employment action, including but not limited to termination.

X _____

Sign your name, DO NOT PRINT OR TYPE Date