Archdiocese of St. Louis Health Insurance
Enrollment/Change/Cancellation/Waive Form

*This form automatically enrolls/changes/cancels/waives you and your dependent(s) for Medical and Prescription coverage provided by UnitedHealthcare, Dental coverage provided by Delta Dental of Missouri, and Vision coverage provided by Delta Vision.

Please check one box:
☐ Open Enrollment ☐ Enroll ☐ Change ☐ Cancel ☐ Waive

Effective Date of Action: **(Required)**
*Please note that coverage ends on the last day of the month of termination.

A. QUALIFYING EVENT

Date of Qualifying Life Event

*Supporting documentation required for the qualified life events marked with an asterisk.

☐ New Hire
☐ Transfer from/to:
☐ Loss of Other Coverage*
☐ Spouse/Dependent: Begins New Job
☐ Marriage, Divorce, or Legal Separation*
☐ Birth of Child, Adoption, or Placement in Employee's Home*
☐ Dependent Reaching Maximum Dependent Age
☐ Death of Spouse/Dependent
☐ Court Order/Judgment/Decree*
☐ Spousal Surcharge Status
☐ Other (Describe):

B. EMPLOYEE INFORMATION

☐ Check box if providing a new name and/or new address.

Last Name	First Name	MI	SSN (last 4 digits) or Employee Number
			xxx-xx-

Address	Apt #	City	State	Zip Code

Phone Number	Email Address	Date of Hire

Date of Birth	Gender	Marital Status
	☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widower/Widow ☐ Religious

C. COVERAGE SELECTIONS – Select Plan option

TOTAL MONTHLY PREMIUM	UnitedHealthcare	
	Standard Plan FT/PT	Premier Plan FT/PT
Employee Only	☐ $90.00/$240.00	☐ $131.00/$351.00
Employee + One (Complete Section D)	☐ $331.00/$663.00	☐ $440.00/$881.00
Family (Complete Section D)	☐ $447.00/$895.00	☐ $555.00/$1,111.00
Waive	☐ I do not wish to enroll in coverage at this time.	

Notice of Enrollment Rights: I acknowledge that I have been offered the opportunity to enroll in health insurance coverage through my employer. I understand that if I choose to waive coverage for myself and/or any eligible dependent(s) that enrolling for coverage at a later date would be subject to treatment as a late enrollee and that I may only enroll during an annual open enrollment period or during a Special Enrollment Period, provided that I request enrollment within 31 days after such event.

D. SPOUSE AND DEPENDENT INFORMATION

Check Appropriate Box	Last Name	First Name	Social Security Number	Gender	Relationship	Date of Birth	Other Insurance
☐ Enroll ☐ Cancel				☐ M ☐ F	**Spouse**		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	**Dependent**		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	**Dependent**		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	**Dependent**		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	**Dependent**		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	**Dependent**		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	**Dependent**		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	**Dependent**		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	**Dependent**		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	**Dependent**		☐ Y ☐ N

E. SPOUSAL SURCHARGE

Employee Attestation: A spousal surcharge is an extra charge to an employee for insuring a spouse who has coverage available through his/her own employer. For further questions, go to **http://archstl.org/spousalsurcharge**.

By completing the Spousal Surcharge section of this enrollment form, I attest that the provided information is true and complete to the best of my knowledge. I also understand that if my spouse's group health insurance status changes, it is my responsibility to notify my employer's benefits administrator within 31 days of such change. It is also my responsibility to ensure on a timely basis that my paycheck withholding correctly reflects my surcharge exemption. Any false statements, as it relates to my spousal health insurance information, shall be considered grounds for disciplinary action up to and including termination. I permit the Archdiocese to verify that my attestation is correct.

If you are not eligible for an exemption, please check the box below:

☐ I acknowledge that a Spousal Surcharge fee of $200 per month will be applied.

If you are exempt from the spousal surcharge, please check the box next to one of the following:

☐ My spouse is not employed.
☐ My spouse is self-employed, does not provide themselves employer-subsidized health insurance coverage, and is not eligible for employer-subsidized health insurance.
☐ My spouse is employed with an Archdiocese of St. Louis parish, agency, or school.
☐ My spouse is employed and is not eligible for his/her employer's health insurance coverage.
☐ My spouse is employed and my spouse's employer does not offer health insurance coverage.
☐ My spouse is employed and is eligible for his/her employer's health insurance coverage but the full premium cost is paid by the employee. There is NO employer contribution toward the cost of the health insurance.

If you are not covering a spouse/spouse canceled from health insurance, please check the following box: ☐

F. EMPLOYEE SIGNATURE (PLEASE RETURN COMPLETED FORM TO YOUR LOCAL EMPLOYER REPRESENTATIVE.)

HIPAA electronic consent language: The Health plan provides medical, dental, vision, and flexible spending account benefits. Under federal law, we are required to provide you with a Notice of Privacy Practices (the 'Notice') of how medical information obtained through the Health plan may be used and disclosed and how you can get access to that information. I understand that the Notice is provided here within this form, but will be provided to me electronically in the future, and that I may also request a paper copy of the Notice at any time by contacting the Archdiocese of St. Louis Human Resources – Benefits Specialist at **Humanresources@archstl.org** or **314.792.7540**. The Notice is also available online at **https://www.archstl.org/human-resources**. I also understand that if I choose not to receive the Notice electronically, or if my email address needs updated, then I must notify the Archdiocese of St. Louis Human Resources – Benefits Specialist at **Humanresources@archstl.org** or **314.792.7540**.

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 Termination Rights: I understand that if my health insurance premium is deducted on a pre-tax basis, then I am limited as to when I may drop coverage under this plan: during open enrollment or upon a qualifying life event.

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 Confirmation: I confirm that the information I have provided on this form is complete and accurate.

Employee Signature _____ **Date** _____

G. EMPLOYER SECTION: FOR ADMINISTRATION TO COMPLETE

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of this 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 date of signature. Retain the original in your employee's medical file whether the employee is waiving or electing coverage. Within 31 calendar days of the hire date, qualifying event, or termination: **Please fax the completed form to 314.792.7548, mail to the Office of Human Resources at 20 Archbishop May Dr., St. Louis, MO 63119, or submit via email to your designated HR coordinator..**

Employment Status: (Check one) ☐ Full-Time ☐ Part-Time

Employer **Process Level**

EMPLOYER Signature **Date:**

Position/Title **Phone Number:** **EMPLOYER Email Address:**

NOTICE OF PRIVACY PRACTICES

Archdiocese of St. Louis Group Health Plan

Effective Date: April 14, 2003
Last Revision Date: April 14, 2022

This Notice Describes How Your Protected Health Information May Be Used and Disclosed and How You Can Get Access To This Information.

Please Review It Carefully.

Who Will Follow This Notice

This notice describes the medical information practices of the Archdiocese of St. Louis' Group Health Plan (the "Plan") and that of any third party that assists in the administration of Plan claims. This Notice describes the Privacy Practices of the health programs on Exhibit A offered under the Plan, which may be updated from time to time.

Our Pledge Regarding Protected Health Information

The Plan understands that your protected health information and your health is personal. The Plan is committed to protecting your protected health information. This notice applies to all of the medical records the Plan maintains. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your protected health information created in the doctor's office or clinic.

This notice will tell you about the ways in which the Plan may use and disclose your protected health information. It also describes obligations and your rights regarding the use and disclosure of protected health information.

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to you protected health information
- give you this notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the notice that is currently in effect.

The Plan reserves the right to change the terms of this Notice and to make new provisions about your protected health information that it maintains, as allowed or required by law. The Plan will provide you with a copy of revised Notices of Privacy Practices if any material changes are made by making it available to you upon request and by posting it on its website.

How We May Use and Disclose Your Protected Health Information

The following categories describe different ways that the Plan uses and discloses protected health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. The Plan may use or disclose your protected health information to facilitate medical treatment or services by providers. The Plan may disclose protected health information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, disclosure of information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

For Payment. The Plan may use and disclose your protected health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Pan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. Also medical information may be shared with a utilization review or precertification service provider. Likewise, medical information may be shared with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. The Plan may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the use of medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage, submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs: business planning and development such as cost management; and business management and general Plan administrative activities.

As Required By Law. The Plan will disclose your protected health information when required to do so by federal, state or local law. For example, disclosure of medical information when required by a court order, in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, disclosure of your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, your protected health information may be disclosed to certain employees of the Employer. Those employees will **only** use or disclose that information as necessary to perform plan administration functions or as otherwise required or permitted by HIPAA. Your protected health information may not be used for employment purposes without your express authorization.

Special Situations

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan (as described by HIPAA) for purposes of facilitating claims payments under that plan.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release protected health information as required by military command authorities. The Plan may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths,
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose your protected health information in response to a court or administrative order. The Plan may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena. warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if. under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the hospital, and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may release your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release protected health information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, your protected health information may be released to the correctional institution or law enforcement official. This release would be necessary:

(a) for the institution to provide you with health care:
(b) to protect your health and safety or the health and safety of others, or
(c) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state a time period which may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information used or disclosed about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information disclosed about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to. In your request, you must tell us:

(a) what information you want to limit;
(b) whether you want to limit our use, disclosure or both; and
(c) to whom you want the limits to apply, for example, disclosures to your spouse.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

A Note About Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child. The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Right to Accounting of Electronic Health Records. If a "covered entity" maintains an "electronic health record" about you, you have the right to (1) obtain a copy of the information in electronic format and (2) tell the covered entity to send the copy to a third party. The covered entity may charge you a reasonable fee for labor costs for sending the electronic copy of your health information.

Right to be Notified of a Breach. You have the right to be notified in the event that the Plan (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website:
https://www.archstl.org/human-resources/employee-benefits-and-forms/administration

Changes to This Notice

The Plan reserves the right to change this notice. The Plan reserves the right to make the revised or changed notice effective for medical information already available about you as well as any information received in the future. A copy of the current notice will be posted on the Plan website. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

The Plan welcomes an opportunity to address any concerns that you may have regarding the privacy of your health information. If you believe that the privacy of your health information has been violated, you may file a complaint with the Contact Person listed below. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint. **You will not be penalized or retaliated against for filing a Complaint.**

CONTACT PERSON

Archdiocese of St. Louis Human Resources/Benefits - HIPAA
Address: 20 Archbishop May Drive
St Louis, Missouri 63119
Email Address: Humanresources@archstl.org
Telephone Number: 314-792.7540

Exhibit A

Health Plans Included in this Notice:

UnitedHealthcare
Delta Dental
Flex Spending Program
Employee Assistance Program
Wellness Program

PRINT