Archdiocese of St. Louis Health Insurance

Employee Enrollment/Change/Cancellation Request Form

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

Please check one box:

☐ Enroll ☐ Change ☐ Cancel ☐ Waive

Effective Date of Action: _____ **(Required)**

**Please note that coverage ends on the last date of employment for terminations.*

A. EMPLOYER SECTION: FOR PARISH, SCHOOL, OR AGENCY 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 per instructions received from Human Resources for your parish/school/agency.

Parish / School / Agency Name	**Employer Benefit Invoice #**

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

☐ New Hire Date _____/_____/_____ (Required for new coverage)	☐ Medicare Eligibility
☐ Transfer from/to: _____ ☐ Loss of other coverage or current enrollment in Cobra Plan*	☐ Death of spouse/dependent: Date of Death _____/_____/_____ (Required)
☐ Spouse/dependent begins new job: Date new job begins _____/_____/_____ (Required) Insurance start date at new job _____/_____/_____ (Required) *Spousal Surcharge may apply.*	
☐ Birth of Child ☐ Adoption/Placement in Employee's Home* ☐ Marriage*	☐ Court Order/ Judgement/ Decree* ☐ Divorce/Legal Separation*
☐ Employee/Spouse/Dependent Status Change *(ex: Part Time to Full Time)* ☐ Employee/Spouse/Dependent reaching maximum dependent age	☐ Significant Cost Change (greater than 10%) ☐ Significant Coverage Decrease
☐ Other (Describe): _____	☐ Spouse/Dependent Open Enrollment* ☐ Marketplace Open Enrollment*
☐ Employee Termination: ☐ Last date of employment _____/_____/_____ (Required)	☐ Continuation of Coverage Plan ☐ Early Retiree Plan ☐ Spousal Surcharge Status

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

EMPLOYER Signature and Position/Title:	Date:

Phone Number:	EMPLOYER Email Address:

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

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

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

Phone Number:	Email Address:

Date of Birth:	Sex: ☐ Male ☐ Female	Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Religious

Who Should be Covered: (Check one):	Health Plan: (Check one)
☐ Employee Only ☐ Employee Plus One (Spouse or Child) ☐ Employee Plus Family ☐ No One (Terming All)	**UHC Choice Plus: Group # 703597** ☐ Standard Plan ☐ Premier Plan

C. SPOUSE AND DEPENDENT INFORMATION – Attach a separate page with additional dependents, if needed.

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

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.

☐ I acknowledge that a Spousal Surcharge fee of $125 per month will be applied. I am not eligible for an exemption.

Check the appropriate box below, if you meet the eligibility for an exemption from the $125 monthly spousal surcharge.

Employee Attestation: I am exempt from the spousal surcharge due to the following checked box (select one):

- ☐ 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.

My employee attestation, as shown above, 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 parish, agency, or school'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.

Check box to acknowledge you agree to the above paragraph. ☐

D. EMPLOYEE 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.

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:

E. WAIVE COVERAGE

I Decline Coverage for (Check All That Apply):	☐ Myself ☐ Spouse ☐ Dependent Children ☐ Myself and all dependents

I acknowledge that I have been offered the opportunity to enroll in health insurance coverage through my employer.

I do NOT wish to enroll myself and/or any eligible dependent(s) in the Archdiocesan health plan at this time. I understand that I may enroll only during an annual open enrollment period or if one of my eligible dependents or I become eligible for a Special Enrollment Period as a result of a permissible change in status.

EMPLOYEE Signature:	Date:

I acknowledge that I have received the "Important Information" statement which is included with this form.

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.