Diocese of Palm Beach
Benefits Office

Group #: 98620
Division #:_____
Location Number:_____
Effective Date of Change:_____
(Box is for Benefits Office Use ONLY)

Employee Change of Information Form

COMPLETION OF THIS FORM DOES NOT GUARANTEE ENROLLMENT INTO
ANY BENEFIT PROGRAM ADMINISTERED BY THE DIOCESE OF PALM BEACH

PLEASE COMPLETE ALL SECTIONS OF THIS FORM. YOU MUST SIGN AND THE BENEFITS OFFICE MUST VALIDATE.

1. PERSONAL INFORMATION

Name:

_____ _____ _____
Last **First** **Middle**

Social Security Number _____

Home Address:

_____ _____ _____
Street Apt# City

_____ _____
State Zip Code

Home Telephone Number: ( )_____ - _____ **Marital Status:** _____ Single ____ Married ____ Divorced ____ Widowed

Birth Date: _____ **Sex: Male ____ Female ____** **Employment Date**:_____

Occupation: _____ Religious _____ Laity _____

Have you been or are you now employed by another Participating Employer of the Diocese of Palm Beach at any time prior to this period of Employment? **___ yes ___ no** If yes, indicate employer(s), address(s) and dates of employment below.

_____
Name and Address of previous or current Employer(s) Parish, School, Agency From _____ **To**: _____

2. TYPE OF CHANGE (Check the appropriate box(s) and indicate effective date of change.)

Date of Event: _____

- ☐ Re-Hire
- ☐ Transfer (Indicate Previous Employer): _____
- ☐ Address Change
- ☐ Name Change (Indicate former name and include a copy or marriage certificate or divorce decree):
  From _____ to _____
- ☐ Social Security Number Change (Indicate former number and include a copy of your new social security card): _____
- ☐ Family Status Event: ☐ Marriage ☐ Divorce ☐ Newborn ☐ Adoption ☐ Over-aged Dependent ☐ Loss of Coverage
- ☐ Change of coverage and/or level (Indicate changes in section 3
- ☐ Termination/Retirement/Death: ☐ Yes ☐ No
- ☐ Other:
  _____

3. EMPLOYEE AND DEPENDENT HEALTH COVERAGE

You must complete this section to enroll or waive coverage for yourself and your eligible dependent(s), if any. Eligible dependents are: Your legal spouse and dependent children, through the end of the calendar year in which the child reaches the age of 26. Under certain conditions, dependents may be covered through the end of the calendar year in which the child reaches the age of 30. Handicapped children over the age of 30 meeting certain criteria are eligible for coverage. See the plan booklet for additional details.

Medical Coverage - Choose ***one*** of the plans and levels of coverage listed below or you may waive medical coverage.

Standard PPO – Blue Choice
- ☐ **Employee only**
- ☐ **Employee + 1**
- ☐ **Employee + Family**

Premium PPO – Blue Choice
- ☐ **Employee only**
- ☐ **Employee + 1**
- ☐ **Employee + Family**

☐ **Please check here if you wish to Waive Medical Coverage and attach a copy of your current medical insurance card.**

Dental Coverage – Choose ***one*** of the levels of coverage below or you may waive dental coverage: **This box is for Benefits Office Use Only!**

- ☐ **Employee only**
- ☐ **Employee + 1**
- ☐ **Employee + Family**
- ☐ **Please check here if you wish to Waive Dental Coverage**

Dental

Group #: Religious: FL05162_____

Lay: FL05161_____

Active(Ø) _____

Retiree(8) _____

Continuation(9) _____

Entity Code: _____

Effective Date of Change: _____

Please complete the next section for you and your eligible dependents changes for medical and/or dental coverage

Name	Social Security Number	Date of Birth (mm/dd/yy)	Sex (Circle One)	Relationship to Employee Spouse(SP) Child(CH) Self	Medical ADD (A) TERM (T)	Dental ADD (A) TERM (T)
Self			M F			
Spouse			M F			
Dependent 1 Name:_____ ☐ Disabled ☐ Supported by you ☐ Living with you ☐ FT/PT Student or FL Resident			M F			
Dependent 2 Name:_____ ☐ Disabled ☐ Supported by you ☐ Living with you ☐ FT/PT Student or FL Resident			M F			
Dependent 3 Name:_____ ☐ Disabled ☐ Supported by you ☐ Living with you ☐ FT/PT Student or FL Resident			M F			

4. 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 health 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 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' 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:**