Catholic Employee Benefit Group

WEB TPA employer services

# Catholic Employee Benefit Group
# Health Benefit Enrollment/Change Form

P.O. Box 99906
Grapevine, TX 76099-9706
800-953-2024

| Today's Date | Hire Date | Effective Date | Group Number |
|---|---|---|---|
| | | | **2008CEBG** |

New hires must complete entire form. Changes should indicate only employee's name, social security number and items changed.

**Subgroup** ☐ **0001 Amarillo** ☐ **0002 Corpus** ☐ **0003 Lubbock** ☐ **0004 Tyler**

CLASS _____ LOCATION _____

**Section 1 - Employee Information (please print clearly)**

| Employee Name (last, first) | Social Security # | DOB | Gender: (M/F) |
|---|---|---|---|
| | | | |

| Mailing Address(please use P.O.Box if applicable) | City | State | Zip | Home Phone |
|---|---|---|---|---|
| | | | | |

**Section 2 - Enrollment/Change**

**Reason for Enrollment/Change is due to:** **Date of Change:** _____

☐ New Employee ☐ Open Enrollment ☐ Late Enrollment
☐ Marriage ☐ Divorce ☐ Death of Spouse or Child
☐ Birth or Adoption of Child ☐ Spouse becomes employed ☐ Spouse ceases to be employed
☐ Separation of Employment Other: _____

**Section 3 – Plan Options**

Medical: ☐ Employee Only ☐ Employee Plus Spouse ☐ Employee Plus Child(ren) ☐ Employee Plus Family

Dental: ☐ Employee Only ☐ Employee +1 ☐ Employee + 2

**Section 4 - Dependent Information: Adding Dependents**

| Name | Sex (M/F) | DOB | SS# | Relationship | Address (If Different) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Section 5 - Dependent Information: Dropping Dependents**

| Name | Sex (M/F) | DOB | SS# | Relationship | Address (If Different) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Section 6 - Student Status/Disabled - Dependent Information (over age 19)

| Name | Gender (M/F | DOB | SS# | Relationship | Address (If Different) | Other Insurance Available? |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Section 7 - Other Health Insurance Information

Do you or the other enrollees have additional health insurance? ☐ Yes ☐ No

| Insured Name | Insurance Company Name | Policy Number | Effective Date |
|---|---|---|---|
| | | | |
| | | | |

## Section 8 - Annual Health Plan Information Form and Initial Claim Authorization

I have received, read, and understand materials including the Summary of Benefits in the Enrollment Packet explaining the Health Plan and the Dental Plan. I understand that full Summary Plan Descriptions are available upon request. I understand that by signing and submitting this form, I am making an election concerning my benefits for the enrollment period. This election is binding subject to my right to make changes according to provisions of the program and subject to any changes required to comply with federal tax laws. This enrollment form is not an employment agreement.

If I submit a claim to the Health Plan for myself and/or covered dependents, I hereby authorize any hospital, physician, or other person who has attended me, or examined me to furnish the Health Plan, WEB-TPA or its authorized representative, any and all information requested with respect to any illness or injury, medical history, consultation, prescription, or treatment and copies of all hospital and medical records. I also authorize the Health Plan and WEB-TPA to disclose said information to third party organizations engaged in actuarial, financial, and statistical studies, as well as the State Insurance Regulator for an insurance regulatory purpose statutorily authorized by the state and to Peer Review Organizations, when necessary. A photocopy of this authorization shall be considered as effective and valid as the original. By signing this form, I submit my annual information review and initial claim authorization. I understand that claims submitted under this authorization will be processed subject to continued proof of eligibility and all plan provisions. I verify that the information on the reverse side of this form is true and correct. I understand that any intentional/knowing falsification of enrollment information is considered fraud and cause for immediate termination of the employee and dependents from the health and/or dental plan(s), with the employee subject to repayment of any funds paid by the Plan.

## Section 9 - ELECTING COVERAGE (check box if electing coverage)

☐ **I am electing coverage for my family or myself at this time.**

**Employee's Signature: _____ Date: _____**

### CREDITABLE COVERAGE
### (If new enrollee to Health Plan)

**A Certificate of Coverage is required in order to offset or waive the pre-existing condition exclusionary period. Can you provide a certificate verifying previous health care coverage? ☐Yes ☐ No**

## Section 10 – ☐ WAIVING COVERAGE (check box if <u>waiving</u> coverage)

**Note: If you are <u>declining</u> enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your 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 30 days after the marriage, birth, adoption, or placement for adoption.**

**<u>I am NOT electing coverage for my family or myself at this time.</u>**

**Employee's Signature: _____ Date: _____**

Catholic
Employee Benefit Group

# Designation of Beneficiary

Name of Employer: Catholic Employee Benefit Group
Group Contract No: _____ Subgroup/Name of Diocese _____
Name of Insured Employee/Member: _____
Insured Member's Social Security Number: _____

## Insured Member's Designation of Beneficiary

Subject to the terms of Group Life Insurance Contract(s) between Catholic Employee Benefit Group (Policyholder) and contracted life insurance company, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me:

**Primary Beneficiary Designation**

| Name of Beneficiary (First, MI, Last Name) | Related To Me As | Date of Birth (Mo./Day/Yr.) | Address of Beneficiary (Address, City, State, Zip) | Percentage (%) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | Percentage Total: | 100% |

**Contingent Secondary Beneficiary Designation**

| Name of Beneficiary (First, MI, Last Name) | Related To Me As | Date of Birth (Mo./Day/Yr.) | Address of Beneficiary (Address, City, State, Zip) | Percentage (%) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | Percentage Total: | 100% |

*If more than one named, the beneficiaries shall share equally unless otherwise stated above.

Unless otherwise above expressly provided, if any beneficiary listed above designated predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries, if any, who survived me, but if no designated beneficiary survives me, the beneficiary shall be determined as prescribed in said Group Contract(s).

If this Designation of Beneficiary refers only to a Group Life Insurance contract and if I am insured also under a Group Death and Dismemberment insurance contract issued by contracted life insurance company, this designation shall apply to both contracts unless I made a separate designation on or after the date of this designation.

This Designation of Beneficiary is subject to change as provided in said Group Contract(s).

_____
Signature of Insured Member

Date of Insured Member's Signature _____

Return original to employer or policy administrator.

## Instructions

1. If a mistake is made, no erasures or corrections should be attempted, but a new form should be used.
2. If a married woman is to be named, her full given name should be shown — for example: Mary J. Smith, not Mrs. John H. Smith. Likewise, if the card is to be signed by a married woman, she should sign her given name.
3. When two or more beneficiaries are to be named and they are not to share equally, the percentage each beneficiary is to receive should be shown; dollars and cents should not be specified.
4. If there are any questions, you should consult the person handling the group insurance at your policyholder's office.