DIOCESE OF
FORT WAYNE-SOUTH BEND
HUMAN RESOURCES

ANTHEM BLUE CROSS/BLUE SHIELD ENROLLMENT / CHANGE FORM FOR MEDICAL, DENTAL, VISION

Group Name: Diocese of Fort Wayne-South Bend Inc. Group # W24101 Location#_____

Employee Information

*Last Name _____ *First Name _____ ◯ Male

Date of Birth _____ *Social Security Number _____ ◯ Female

Street Address _____ Phone _____

City _____ State _____ Zip Code _____ Email _____

Job Title _____ Date of Hire _____

Coverage Information

(Check desired coverage or check waive)	Self	Self/Spouse	Self/Children	Family	Waive
MEDICAL PPO	◯	◯	◯	◯	◯
DENTAL	◯	◯	◯	◯	◯
VISION	◯	◯	◯	◯	◯
MEDICAL HDHP/HSA	◯			◯	◯

HSA Annual Election $ _____ (Payroll deductions will be taken pre-tax)

Other Health Insurance Coverage ◯ Yes ◯ No

Name of Plan (if yes) _____

Form continues on the next page

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DEPENDENT INFORMATION

Dependents must be eligible for coverage under the terms of the plan. If your dependents are covered by any other group benefit program or Medicare, mark yes below and add the name of the plan. You must submit a copy of Marriage and or Birth Certificate if covering spouse or dependents.

	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3	DEPENDENT 4
NAME				
RELATIONSHIP				
SEX	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
DATE OF BIRTH				
SOCIAL SECURITY #				
ADD DATE				
REMOVE DATE				
OTHER HEALTH COVERAGE	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N
NAME OF PLAN				

AUTHORIZATION FOR RELEASE OF INFORMATION

I hearby authorize any doctor, hospital, insurance company, employer, or organization to release any information regarding history, treatment, disability or benefits for claims to Anthem Blue Cross Blue Shield of Indiana. A copy of this authorization shall be valid as the original. I understand the following: This form will be used for benefit information and as a claim form. The information listed above is correct and true. To verify incorrect information on this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct from my pay my contribution (if any) to the cost of the benefits I have selected. If I am declining enrollment for myself or my dependents because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 30 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 30 days after that event.

Signature _____ Date _____

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	DEPENDENT 5	DEPENDENT 6	DEPENDENT 7	DEPENDENT 8
NAME				
RELATIONSHIP				
SEX	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
DATE OF BIRTH				
SOCIAL SECURITY #				
ADD DATE				
REMOVE DATE				
OTHER HEALTH COVERAGE	○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N
NAME OF PLAN				

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Signature n/a Date n/a