Diocese of Gary
dcgary.org

Eligible Lay Employees must enroll in benefits online through ADP Workforce Now.

This form is intended for Priests, Religious, and non-paid entities only.

Enrollment Application

Anthem

Diocese of Gary

9292 Broadway, Merrillville, IN 46410

Group #	Location #	Parish School, Agency Name & Address
00083915		
Anthem use: Plan	Health Effective Date	Dental Effective Date
	/ /	/ /

1. Reason for Application

☐ New enrollment ☐ New hire
☐ Annual open enrollment ☐ Rehire (date) ___/ ___/___
☐ COBRA ☐ Add dependent (see section 3)

Qualifying event _____ Event date ___/___/___

2. Status Change/Event

Event date ___/ ___/___ ☐ Adoption*
☐ Marriage ☐ Legal guardianship*
☐ Birth ☐ Other_____
**Include legal documentation.*

3. Type of Coverage/Plan

Health Coverage	*Dental Coverage - Anthem Dental PPO*
☐ **Employee Only**	☐ Single
☐ **Employee + One**	☐ Family
☐ **Employee + Family**	

4. Employee Information

Last name	First name, M.I.	Date of birth / /	Age	Sex ☐ M ☐ F	Social Security # - -	☐ Single ☐ Divorced ☐ Married

Home address	City	State	Zip code	County (KY residents include Municipality)

Home telephone ( ) -	Business telephone ( ) -	eMail Address

Are you: Retired? ☐ Yes ☐ No	Disabled? ☐ Yes ☐ No	Hospitalized? ☐ Yes ☐ No	Occupation	Full time hire date / /	Hours working per week	Income reported by: ☐ W2

5. Family Information *Spouse and dependents to be enrolled. (Attach a separate sheet if necessary.)*

1 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation)

2 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation)

3 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation)

4 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation)

5 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Court ordered health care benefits? ☐ Yes ☐ No (If yes, include legal documentation)

6. Other Health Coverage	***Please check one:*** ☐ *YES (completed below.)* ☐ *NO*			
On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.				
Provide name, phone number and address of the HMO or insurance company		Policy/certificate number		Effective date / /
Policy/certificate holder's name	Social Security number – –	Date of birth / /	Relationship to applicant	
If you and / or your dependents are enrolled in Medicare complete the following.				
Enrollee's name(s)	**Medicare ID # / Medicaid ID #**	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
		/ /	/ /	/ /
Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date / /	Medicare Part D term date / /	
Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)				

Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
3. I am applying for the benefit selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to benefits or rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my benefits.

Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health benefit plan will be administered by one of the following companies based upon the state in which your employer is located:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

In Missouri: Anthem Blue Cross and Blue Shield is the trade name RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC) and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc.

In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

In Wisconsin: Blue Cross Blue Shield of Wisconsin (''BCBSWi'') administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (''Compcare'') administers the HMO and POS policies.

Thank you for choosing Anthem Blue Cross and Blue Shield.

8. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.	
By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.	
Applicant Signature	Date / /

Employee Change Form Application

Anthem.

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

Please complete this form ONLY when making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the "Anthem Enrollment Application" instead of this form. When completing section 2, be sure to include the date of the event causing the change(s). If you are cancelling coverage for a dependent, changing a PCP, or changing a name, please provide a reason in the designated sections.
Complete in ink and return to your employer, using extra sheets of paper if necessary.
NOTE: Some changes may be made by accessing www.anthem.com. *Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com.*

1. Employer Use: Employer Name and Address:	Diocese of Gary 9292 Broadway, Merrillville, IN 46410					
Group #	Sub-group #	Request Effective Date	Applicant #/Dept. name			
00083915		/ /				
Anthem use: Plan	Health Effective Date	~~Dental Effective Date~~	~~Vision Effective Date~~	~~PCP~~	COB	Pre-ex (date)
	/ /	/ /	/ /	☐ ~~Yes~~ ☐ ~~No~~	☐ Yes ☐ No	/ /

2. Reason for Change
Event date ___/___/___

- ☐ Address
- ☐ Enrollment in Medicare
- ☐ Cancel / Waiving Coverage
- ☐ Conversion
- ☐ Benefit change
- ☐ Cancel dependent
- ☐ PCP change
- ☐ Name change
- ☐ Other _____

3. Type of Coverage/Plan

Health Coverage

PPO – Blue Access

- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family coverage
- ☐ No coverage

Dental Coverage

- ☐ PPO _____
- ☐ Traditional (Indiana and Ohio only)
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family coverage
- ☒ No coverage

Vision Coverage

- ☐ Vision _____
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family coverage
- ☒ No coverage

4. Employee Information **Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

Last name	First name, M.I.	Date of birth	Sex	Social Security #	
		/ /	☐ M ☐ F	– –	☐ Single ☐ Divorced ☐ Married

Home address	City	State	Zip code	County (KY residents include Municipality)

Hours worked per week	~~Anthem PCP name and address*~~	~~Anthem PCP ID number*~~	~~New patient?~~
			☐ ~~Yes~~ ☐ ~~No~~

~~If PCP is a change, please indicate the reason for the change.~~

5. Family Information *Spouse and dependents to be changed/cancelled. (Attach a separate sheet if necessary.)* Only complete Primary Care Physician (PCP) information for HMO or POS products.*

1 ☐ Change ☐ Cancel	Last name	First name, M.I.	
Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____
Reason for change			

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

~~Anthem PCP name and address*~~	~~Anthem PCP ID number*~~	~~New patient?~~ ☐ ~~Yes~~ ☐ ~~No~~

~~If PCP is a change, please indicate the reason for the change.~~

2 ☐ Change ☐ Cancel	Last name	First name, M.I.	
Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____
Reason for change			

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

~~Anthem PCP name and address*~~	~~Anthem PCP ID number*~~	~~New patient?~~ ☐ ~~Yes~~ ☐ ~~No~~

~~If PCP is a change, please indicate the reason for the change.~~

3 ☐ Change ☐ Cancel	Last name	First name, M.I.	
Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____
Reason for change			

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

~~Anthem PCP name and address*~~	~~Anthem PCP ID number*~~	~~New patient?~~ ☐ ~~Yes~~ ☐ ~~No~~

~~If PCP is a change, please indicate the reason for the change.~~

Signature required on the reverse side of this form.

6. Other Health Coverage *Please check one:* ☐ YES *(complete below)* ☐ NO

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number	Effective date / /
Policy/certificate holder's name	Social security number – –	Date of birth / /	Relationship to applicant

If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following.

Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
		/ /	/ /	/ /

Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date / /	Medicare Part D term date / /

Reason for Medicare entitlement:

☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

7. Read these Significant Terms, Conditions and Authorizations carefully before signing. Please review your application for errors or omissions.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
3. I am applying for the benefit selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment in the benefit plan. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to benefit rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission of cancellation of my benefits.

Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Applicant Signature	Date / /

Voluntary Waiver of Health Insurance Benefits

1. It has been explained to me, that as an eligible employee, I am entitled to participate in the Diocese of Gary Health Care Insurance Plan.

2. I understand that if I participate in the plan, I would contribute only twenty dollars ($20.00) each month for my coverage and any cost for dependent coverage if applicable. My employer will pay the remaining costs for my own participation in the plan.

3. I realize that in waiving participation in the plan, I am also waiving any claim to contributions, which would have been made, on my behalf for health insurance coverage.

4. I understand that periods of service during which I do not participate in the plan will not count toward "service credit" if I elect to enter the plan at a future date. And, that eligibility for health insurance coverage at retirement is based on years of continuous coverage, not years of continuous employment.

5. I have been informed that a condition of my election not to participate in the plan is proof that I am covered by another health insurance plan, other than the Diocese of Gary Health Care Plan.

6. I hereby acknowledge the receipt of the summary Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided separately.

IMPORTANT NOTICE TO LATE ENROLLEES: If you do not enroll within 31 days after becoming eligible, you will be considered a late Enrollee and may need to provide evidence of insurability to Anthem.

Please be advised that I freely choose **not** to participate in the Diocese of Gary Health Care Plan. I state that I have health care coverage in the plan named below:

Name of your insurance plan:

* _____

If you are currently enrolled in an Affordable Care Act Marketplace medical plan, please contact the Human Resources Department.

Policy/Certificate Holder's Name:_____

Please mark one:

☐ I also waive the term life insurance coverage. I understand that by waiving insurance coverage I cannot enroll until the 2022/2023 open enrollment period with an effective date of July 1, 2022 or unless I have a change in status. A change in status needs to be reported to the Human Resources Department within 31 days of the date of the change.

☐ I wish to enroll in the term life insurance coverage and have attached a life insurance beneficiary form. I understand that one dollar ($1.00) a month will be deducted from my payroll check.

Employee Signature _____ Date _____

Printed Employee Name _____

Employer (School, Parish or Institution) _____