

**Employee Enrollment / Change Form**

**Benefits Administered by**



- Initial Group       COBRA       Open Enrollment  
 New Employee       Change (complete change section on reverse side)

ENROLLMENT SERVICES  
PO BOX 8052 • WAUSAU WI 54402-8052

Employee	EMPLOYER NAME ROMAN CATHOLIC DIOCESE OF LEXINGTON		GROUP NUMBER 76530007		EMPLOYEE JOB LOCATION	
	EMPLOYEE START DATE		EARNINGS		HOURS WORKED WEEKLY	
Employee	SOCIAL SECURITY NUMBER			ALTERNATE IDENTIFICATION NUMBER		
	NAME: LAST		FIRST		M.I.	
	ADDRESS		CITY		STATE ZIP E-MAIL ADDRESS	
	DATE OF BIRTH / /		SEX		MARITAL STATUS	
Portability	HOME TELEPHONE NUMBER ( )					
	This Health Plan has a Pre-existing illness provision for 12 months or 18 months. Proof of Creditable Health Coverage may reduce this time period. Have you attached a Certificate of Creditable Health Coverage for You and/or all Dependents? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, contact your prior plan/employer or insurer to obtain a copy. If necessary, we will assist you. If a certificate is not available, other forms of proof may be submitted.					
Outer Health Coverage	Do you or any family member currently have other health coverage? <input type="checkbox"/> Yes, single <input type="checkbox"/> Yes, family <input type="checkbox"/> No If yes to the above question, complete the following:   Person's Name _____ Employer Name _____   Carrier Name _____   Plan Number _____					
	Do you or any family member currently have other dental coverage? <input type="checkbox"/> Yes, single <input type="checkbox"/> Yes, family <input type="checkbox"/> No If yes to the above question, complete the following:   Person's Name _____ Employer Name _____   Carrier Name _____   Plan Number _____					
Coverages	• Health Coverage: <input type="checkbox"/> <b>Medical Plan</b> Class # _____ <input type="checkbox"/> Employee <input type="checkbox"/> Employee plus one <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Employee plus child/children <input type="checkbox"/> Family <input type="checkbox"/> Waive .....					

**IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.**

