



Diocese of Cheyenne

Complete and return only if enrolling or making changes – Form

**MEDICAL AND DENTAL
ENROLLMENT/CHANGE FORM** (Please print)

Be Completed by Employer	Group Name: Diocese of Cheyenne	Control:	Class Code:	Suffix:	Account:
Location Name:	Group Number: 801104	Division:	Payroll Ded \$:	HR Rep:	Date:

EMPLOYEE INFORMATION

Employee Last name:	First:	Middle:	Social Security No:
Street address:	City, State, Zip	Home Phone Number:	Cell Phone Number:

Plan Activity

Enrollment: <input type="checkbox"/> New Enrollee/Subscriber Effective Date: ___/___/___ Date of Hire: ___/___/___	Classification: <input type="checkbox"/> Lay Employee/Religious <input type="checkbox"/> Priest	Change: <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other <input type="checkbox"/> Change Plan <input type="checkbox"/> Control/Suffix/Acct/Plan.	Remove or Terminate – Check all that apply <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal/Termination Date of Event: ___/___/___ Reason: _____ Effective Date: ___/___/___ Reason: _____
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Medical Plan Options:	<input type="checkbox"/> Elect Medical PPO <input type="checkbox"/> Waive Medical <input type="checkbox"/> Employee <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Family
Dental Plan Options:	<input type="checkbox"/> Elect Dental PPO <input type="checkbox"/> Waive Dental <input type="checkbox"/> Employee <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Family

INDIVIDUALS COVERED – LIST INDIVIDUALS FOR WHOM YOU ARE ADDING/CHANGING/REMOVING COVERAGE

A = Add C= Change R= Remove	Last Name, First Name, M.I.	Sex	Birthdate MM / DD / YYYY	Social Security Number	Other Medical/ RX Coverage	Handi- capped	Student	Medical	Dental
	Employee	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes to other Medical or Rx coverage above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your Member ID number.	Does any dependent listed above live at a different address than the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who and what address?
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I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have agreed to the Conditions of Enrollment. I agree and understand that my premiums will be deducted pre-tax from each paycheck.	Employee Signature - Required		Do you have a disability which affects your ability to communicate or read? If "Yes", please contact your HR Department.
	Date	E-Mail address	