



Open Enrollment Form

Effective Date:

July 1st

1. Employee Information

* Location Name:	Diocese of Covington			* Location#:	82900
* Last Name:		* First Name:			
* Home Address:					
* City:		* State:		* Zip Code:	
* Social Security #:		* Date of Birth:			
* E-mail Address:		* Home/Cell Phone:			
* <input type="checkbox"/> Male <input type="checkbox"/> Female		* <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Religious			

2. Benefit Election(s) or Waiver of Medical Coverage

During this open enrollment period, I request to enroll myself and any applicable dependents below to the benefits my employer offers and following the group's "tiered" structure with the type of coverage as chosen here:

Who is to be Covered

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Family

Type of Coverage

- Medical
- Medical
- Medical
- Medical

**** Dependents cannot be enrolled in coverage(s) not selected by the employee and coverage(s) must match ****

Dependent Information

List the name of each dependent and answer each question for each dependent	Social Security Number	Birthdate MM/DD/YY	Sex M/F	Are you Legal Guardian	Step-Child	Disabled Dependent
Spouse:				N/A	N/A	N/A
List Children Below						

Waiver of Medical Coverage

I hereby certify that I have been given an opportunity to apply for medical coverage. I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a qualifying event/special enrollment opportunity or during the next open enrollment period. I decline coverage for:

- Myself Spouse Dependent Child(ren) Myself and all Dependents
- Due to:** Spouse's Plan Individual Policy Medicare Medicaid Enrolled with another employer plan
- Other; please explain:

Signature of Employee:		Date:	
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