

**MICHIGAN CATHOLIC CONFERENCE  
PARTICIPANT HEALTH CARE ENROLLMENT FORM  
THIS FORM SHOULD BE COMPLETED IN BLUE OR BLACK INK**

<b>1a. EMPLOYEE INFORMATION</b>										
SSN	EMPLOYEE LAST NAME			FIRST NAME			MIDDLE NAME			
STREET ADDRESS				CITY			STATE	ZIP CODE		
PHONE NUMBER (INCLUDE AREA CODE)	EMPLOYMENT STATUS			MARITAL STATUS		GENDER		MEDICARE IDENTIFICATION NUMBER:		
DATE OF BIRTH	<input type="checkbox"/> LAY EMPLOYEE <input type="checkbox"/> DIOCESAN PRIEST <input type="checkbox"/> RELIGIOUS COMMUNITY MEMBER OR ORDER PRIEST			<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		(PLEASE ATTACH COPY OF CARD) MEDICARE EFFECTIVE DATES		
PART A: PART B:										
<b>1b. EMPLOYER INFORMATION</b>										
EMPLOYER NAME			CITY		EMPLOYER CONTACT PERSON			EMPLOYER PHONE NUMBER		
OCCUPATION	HOURS PER WEEK:	MONTHS PER YEAR:	DATE OF HIRE	EFFECTIVE DATE OF COVERAGE			UNIT NUMBER			
<input type="checkbox"/> <b>I DECLINE COVERAGE BECAUSE I AM COVERED UNDER ANOTHER INSURANCE. <u>EMPLOYER SHOULD ATTACH A COPY OF THE INSURANCE CARD(S) AND RETAIN THIS FORM FOR THEIR FILES ONLY.</u> By placing an X in the box, I am declining all health benefits offered to me at this time.</b>										
<b>2a. MEDICAL COVERAGE OPTIONS</b> Select the Medical Coverage you prefer and place an X in the appropriate box below.										
<input type="checkbox"/> <b>Community Blue PPO coverage provided by BLUE CROSS BLUE SHIELD OF MICHIGAN</b>					<input type="checkbox"/> <b>Supplemental coverage to Medicare provided by BLUE CROSS BLUE SHIELD OF MICHIGAN</b>					
<i>If you enroll in Blue Care Network, you must also complete a BCN Primary Care Physician form and attach it to this enrollment form.</i>										
<input type="checkbox"/> <b>BLUE CARE NETWORK HMO East Michigan Region</b>			<input type="checkbox"/> <b>BLUE CARE NETWORK HMO Southeast Michigan Region</b>			<input type="checkbox"/> <b>BLUE CARE NETWORK HMO Mid Michigan Region</b>				
<input type="checkbox"/> <b>BLUE CARE NETWORK HMO West Michigan - Traverse City Region</b>			<input type="checkbox"/> <b>BLUE CARE NETWORK HMO West Michigan - Kalamazoo Region</b>			<input type="checkbox"/> <b>BLUE CARE NETWORK HMO West Michigan - Grand Rapids Region</b>				
<b>2b. DENTAL COVERAGE OPTION</b>										
<input type="checkbox"/> <b>Dental coverage provided by DELTA DENTAL PLAN OF MICHIGAN</b>										
<b>3. MEMBERSHIP INFORMATION:</b> Please list any members you will be covering, <i>including the employee.</i> Complete all sections for each person listed. If additional space is needed, please attach a separate sheet of paper listing the additional members to be covered.										
LAST NAME	FIRST NAME	MIDDLE NAME	M/F	DATE OF BIRTH	RELATIONSHIP	SSN	COVERAGE SELECTED			
					<b>EMPLOYEE</b>		MEDICAL	DENTAL		
					<b>SPOUSE</b>					
					<b>DEPENDENT</b>					
					<b>DEPENDENT</b>					
					<b>DEPENDENT</b>					
<b>4. FLEXIBLE BENEFIT PLAN – PREMIUM SHARING ACCOUNT ONLY</b>										
I UNDERSTAND I CAN ELECT TO PARTICIPATE IN THE FLEXIBLE BENEFIT PLAN PREMIUM SHARING ACCOUNT AND PAY FOR MY PORTION OF THE MEDICAL AND/OR DENTAL PREMIUMS WITH PRE-TAX DOLLARS. BY ELECTING TO PARTICIPATE IN THE PREMIUM SHARING ACCOUNT, MY MONTHLY CONTRIBUTION WILL NOT BE SUBJECT TO FEDERAL, STATE, and LOCAL, OR FICA TAXES.										
<input type="checkbox"/> <b>I ELECT TO PARTICIPATE IN THE FLEXIBLE BENEFIT PLAN - PREMIUM SHARING ACCOUNT</b>										
<b>5. OTHER GROUP HEALTH CARE COVERAGE:</b> Are you or your dependents covered by another insurance? ATTACH A COPY OF THE INSURANCE CARD AND LIST THE PERSONS COVERED BY THIS INSURANCE.										
NAME OF INSURED	DOB	SSN	NAME AND ADDRESS OF INSURER		EFFECTIVE DATE OF COVERAGE	GROUP/POLICY NUMBER	NAME AND ADDRESS OF EMPLOYER			
<b>6. THIS FORM MUST BE SIGNED AND DATED BY THE APPLICANT IN ORDER TO BE VALID. I APPLY ON MY BEHALF AND ON BEHALF OF ANY ELIGIBLE DEPENDENTS LISTED ABOVE FOR THE COVERAGE BEING OFFERED. I UNDERSTAND AND AGREE TO THE TERMS ON THE BACK OF THIS FORM.</b>										
<b>SIGNATURE</b>					<b>DATE</b>					
					<b>FOR MCC USE ONLY</b>					
					BCBSM GROUP/SUFFIX ID:			BCN GROUP/SUBGROUP/CLASS ID:		

THE INFORMATION SUPPLIED ON THE FACE OF THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH THE MICHIGAN CATHOLIC CONFERENCE:

- ◆ I am applying for the coverage specified in the Group Operating Agreement with the MCC.
- ◆ Coverage for myself and my eligible enrolled members will begin:

within sixty (60) days of becoming eligible, i.e., the first sixty (60) days of employment. An enrollment form must be completed and signed within that 60 days and coverage will be effective the first day of the month following the date the form was signed.

Or

The first day of the month as designated by the MCC for an open enrollment period.

- ◆ Eligible members are:
  - All regular full-time employees.
  - Spouse of eligible employees.
  - Dependent unmarried children by birth, legal adoption, legal guardianship, and/or spouse's children legally residing with participant through December 31 of the year they turn age 19.
  - Dependents who meet the eligibility requirements listed below may continue coverage under the contract until the end of the calendar year in which they reach the age of 25, if they remain eligible. Community Blue PPO covers these individuals as family continuation riders at an additional premium. BCN and Delta Dental cover them as regular family members. Please check with your employer if an additional premium will be charged. To be eligible, dependents must meet **ALL the following requirements:**
    - Be unmarried and between 19 and 25 years of age.
    - Be dependent on you for more than half their support.
    - Be a member of your household.
    - Be related to you by blood, marriage, or legal adoption.
    - Be a full-time student for at least five months of the year **OR** had a gross income of less than four times the personal exemption amount identified in the IRS gross income test.
  - Persons over age 25 may be covered as sponsored dependents. To be eligible, they must be dependent on participant for more than half of their support, reported on the most recently filed federal income tax return, related to participant by blood or marriage **and** are members of the household. **These individuals would not be eligible for dental benefits.** Please check with your employer regarding the additional premium.
- ◆ I appoint my employer as my agent to handle all matters regarding health coverage. My employer may forward any mutually agreed deductions from my wages for coverage. I am responsible for giving notice of changes in my status and that of my family members which may affect coverage.
- ◆ I authorize MCC and its agents to obtain from providers of service any hospital and medical records relating to me and my family for the purpose of certification of hospital confinement, continued stay review, discharge planning, billing audits and to determine benefits coverage.
- ◆ When MCC accepts my enrollment form, my enrolled family members and I are bound by all conditions stated in the MCC contract.