



# EMPLOYER & PARTICIPANT INFORMATION

NEW HIRE  
LAY BENEFITS

EMPLOYER NAME

(PARISH - SCHOOL - INSTITUTION)

LOCATION #

DOL

GROUP # L06588

SAFS USE ONLY: EFFECTIVE DATE

## PARTICIPANT INFORMATION

REQUIRED FOR ALL PAYROLL EMPLOYEES

First Name

M.I.

Last Name

Phone Number

Social Security Number

Address

City

State

Zip Code

Personal Email

Birth Date

Male Female Single Married

Full Time Part Time Full Time Part Time  
Year Round Year Round School Year School Year

Job Title

1st Day  
of Work

Hours per  
Week

## BENEFIT ELECTIONS: PLEASE SELECT ONE FROM EACH ELECTION

\*Please select Don't Qualify if working less than 30 hrs/week

### Medical Coverage

Single

Family

Waive

Don't Qualify

### Medical Plan (Skip if Waiving Coverage)

Traditional

High Deductible HSA

"The Max" HSA

### Vision Coverage (Included with Medical)

Single

Family

Waive

Don't Qualify

### Dental Coverage

Single

Single + 1

Family

Waive

Don't Qualify

First Name	M.I.	Last Name	Relationship	Gender	Birthdate	Social Security Number	Enrollment
							Medical Vision Dental
							Medical Vision Dental
							Medical Vision Dental
							Medical Vision Dental
							Medical Vision Dental

## OTHER INSURANCE COVERAGE

As of your effective date, will there be any other insurance in effect for you or any dependents listed above? If Yes, please complete below.

Primary Insured	Medical Carrier	Policy - Group Number	Effective Date	Single	Family	Vision	Dental

Dependents Covered: First & Last Name - One Dependent per Box


### Medical Release - Acceptance - Authorization

I hereby authorize any doctor, hospital, insurance company, employer, or organization to release any information regarding history, treatment, disability, or benefits, but excluding genetic information and family history, for claims to Diocesan Third Party Administrator. A copy of this authorization shall be valid as the original. I UNDERSTAND THE FOLLOWING: This form will be used for benefit information. The information listed above is correct and true. To verify incorrect information on this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct my contribution (if any) for the cost of the benefits I have selected from my paycheck. If I am declining enrollment for myself or my dependents because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 31 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 31 days after that event. I certify the above is true and correct and acknowledge I have been given the opportunity to enroll in the Diocese of La Crosse Group Health, Vision, Dental, & Basic Life Insurance Plans. By not enrolling in certain benefits at this time, I realize I will not be able to enroll or make changes again until the next open enrollment unless I have a qualifying event or family status change.

Participant Signature - Required

Date