Diocese of La Crosse
St. Ambrose Financial Services

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 Year Round | Part Time Year Round | Full Time School Year | Part Time School Year | Job Title | 1st Day of Work | Hours per Week

BENEFIT ELECTIONS: PLEASE SELECT ONE FROM EACH ELECTION

Medical Coverage
- Single
- Family
- Waive
- Don't Qualify *(I work less than 30 hrs)

Medical Plan (Skip if Waiving Coverage)
- Traditional
- High Deductible HSA
- "The Max" HSA

Vision Coverage (Included with Medical)
- Single
- Family
- Waive
- Don't Qualify *(I work less than 30 hrs)

Dental Coverage
- Single
- Family
- Waive
- Don't Qualify *(I work less than 30 hrs)

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