



QUALIFYING EVENT FORM FOR GROUP COVERAGE

A. EMPLOYEE INFORMATION

Employee's Last Name, First Name, M.I., Social Security Number, Home Phone, Employee's Home Address, Street, City, State, Zip Code, Work Phone

B. LIST ALL INDIVIDUALS TO BE ADDED OR CANCELLED - COMPLETE ALL THAT APPLY (USE EXTRA PAPER IF NECESSARY)

Table with columns: Relation, Last Name, First Name, M.I., Add/Cancel, Sex, Marital Status, Social Security #, Birth Date (Mo.Day Yr.)

C. BENEFIT SELECTION - CHECK APPROPRIATE BOXES TO ELECT COVERAGE

Coverage Selected: Medical: [] Single [] Family Coverage Level: [] \$1000 Deductible [] \$6350 Deductible

D. CURRENT AND PREVIOUS COVERAGE - Failure to fully complete this section may result in a pre-existing condition limitation. Please attach copies of all certificates of prior coverage.

Do you or any family member listed on this application, have any current health coverage or had previous health coverage within the last 63 days? [] Yes [] No If YES you must fully complete the following Section
If you or any family member applying for this coverage is currently covered by Blue Cross and Blue Shield of Minnesota, Blue Plus, or Delta Dental, do you want that coverage canceled? [] Yes [] No
If YES, provide the individual's name, identification number, group number and cancellation date:

Starting with the employee, list each family member applying for our coverage and include information for all current and previous coverage in effect during the last 18 months. Make sure to include information for other Blue Cross and BlueShield of Minnesota coverage:

Table with columns: Family Member Name, Insurance Company (name and policy number), Date Coverage Started, Date Coverage Ended, Reason for Termination

E. MEDICARE INFORMATION

Are you or your spouse covered by Medicare Part A (Hospital) and Part B (Medical)? Yes (complete section below)
Employee: Effective Date Part A, Effective Date Part B, Medicare Claim Number, Eligibility reason for Medicare: [] Age [] Disability [] End-Stage Renal Disease [] Disability & End-Stage Renal Disease
Spouse: Effective Date Part A, Effective Date Part B, Medicare Claim Number, Eligibility reason for Medicare: [] Age [] Disability [] End-Stage Renal Disease [] Disability & End-Stage Renal Disease

F. COVERAGE CHANGE INFORMATION - CHECK APPROPRIATE BOX(ES) AND COMPLETE SECTION A, B, C and G

Adding dependents:	Date of event	Cancelling dependents:	Date of event
<input type="checkbox"/> Birth/adoption	_____	<input type="checkbox"/> Divorce	_____
<input type="checkbox"/> Court order	_____	<input type="checkbox"/> Other (please explain)	_____
<input type="checkbox"/> Marriage	_____ County _____	Details _____	
<input type="checkbox"/> Other	_____		
<input type="checkbox"/> Loss of prior health and/or dental coverage:		<input type="checkbox"/> Address change	
Did you lose health coverage, dental coverage or both?	_____	<input type="checkbox"/> Primary care clinic change	
	Date of event _____	<input type="checkbox"/> Phone number change	
<input type="checkbox"/> Other coverage voluntarily terminated	_____	<input type="checkbox"/> Name change	
<input type="checkbox"/> Group continuation (COBRA) period exhausted	_____	Previous _____	
<input type="checkbox"/> Employer contribution for coverage terminated	_____	List new name is Section A	
<input type="checkbox"/> Coverage terminated due to loss of eligibility	Reason _____		

G. SIGNATURE

AUTHORIZATION OF COVERAGE

MY SIGNATURE AUTHORIZES ANY PAYROLL DEDUCTION REQUIRED TO PARTICIPATE IN THE PLAN. I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X	Month	Date	Year

Signature of Employee

Date Signed

WAIVER OF COVERAGE

I HAVE BEEN INFORMED THAT I AM ELIGIBLE TO ENROLL FOR COVERAGE THROUGH MY EMPLOYER. I DO NOT WANT COVERAGE.

X	Month	Date	Year

Signature of Employee

Date Signed

H. THIS PART TO BE COMPLETED BY EMPLOYER

Employee date of employment (MM/DD/YY):	Employee occupation:	Hours worked per week:
Indicate the reason employee is enrolling for coverage:		
<input type="checkbox"/> Qualifying Event	Date of Event _____	
Group Numbers:		
Health _____	Dental _____	
Department Number _____		
I certify the above information to be true and correct.		
Signature _____		Date _____
Employer Name Diocese of Winona	Telephone number (507) 858-1268	Fax number (507) 454-8106

ENROLLMENT / CHANGE FORMS SHOULD BE SENT TO:

Diocese of Winona
PO Box 588 OR Fax: OR E-mail:
Winona, MN 55987 (507)454-8106 benefits@dow.org

Questions? Contact the Employee Benefits Coordinator at (507)858-1268 or benefits@dow.org