

Listed below are the health plan choices offered by your group and the associated monthly rates for each, effective January 1, 2014. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2014 Health Plan Choices and indicate the Tier (Single, etc.)

Member Information

Name _____
 Address _____
 City, State Zip _____
 Date of Birth _____ Social Security No. _____
 Hire Date _____ Gender M F

Diocese of Kentucky

0398
 Group # _____ Medical Billing Unit _____
 Employer's Name _____
 Employer's Address _____

Dependent Information

You may obtain coverage for your eligible children who are age 30 or younger. If your group offers domestic partnership coverage, attach supporting documentation with this form. If you wish to enroll one or more dependents, please attach an additional sheet which includes the following information for each: Name, Social Security Number, Gender (M/F), Date of Birth, and Relationship to Employee (Spouse, Child).

2014 Health Plan Choices

		MEDICAL				MEDICAL (check one)	
Option Code	2014 Election (check one) Plan Name	Single	Emp+1	Family	System Code		
MHDE	<input type="checkbox"/> Empire BCBS High Deductible Health Plan	\$469	\$845	\$1,314	EMPHDHP	<input type="checkbox"/> Single	
MSPV	<input type="checkbox"/> Empire PPO 75/50	\$635	\$1,142	\$1,777	BCPPO75	<input type="checkbox"/> Emp+1	
MSPZ	<input type="checkbox"/> Empire PPO 80/60	\$720	\$1,297	\$2,017	BCPPO80	<input type="checkbox"/> Family	
	<input type="checkbox"/> I decline medical coverage						

		DENTAL				DENTAL (check one)	
Option Code	2014 Election (check one) Plan Name	Single	Emp+1	Family	System Code		
DD25	<input type="checkbox"/> Dent&Ortho-25/75	\$67	\$121	\$188	DENTAL25	<input type="checkbox"/> Single	
DD50	<input type="checkbox"/> Basic Dent-50/150	\$50	\$90	\$140	DENTAL50	<input type="checkbox"/> Emp+1	
DDPV	<input type="checkbox"/> Preventive Dental	\$21	\$38	\$59	DENTALBASIC	<input type="checkbox"/> Family	
	<input type="checkbox"/> I decline dental coverage						

When you have made your decision, sign and return this form to your administrator as indicated below.

 Employee's Signature Date

MAIL THIS FORM TO:

Rebecca Meyer
 Diocese of Kentucky
 425 S 2nd St
 Suite 200
 Louisville, KY 40202-1430

TO BE COMPLETED BY THE GROUP ADMINISTRATOR

I hereby certify that this applicant is eligible for coverage and, to the best of my knowledge, all the information provided above is correct.

 Administrator's Signature Date