

**DIOCESE OF MONTEREY**

**Account Number**

**A. Employee information** (Please print using blue or black ink)

Your name (last, first, middle initial)			Social Security number		
Address (street)	City	State	Zip code	County	Phone No.
Date of birth (mo/day/yr)	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> single <input type="checkbox"/> widowed	<input type="checkbox"/> married <input type="checkbox"/> divorced	<input type="checkbox"/> legally separated	

**B. Dependent information: List your spouse and all eligible Dependent children.**

Name of Spouse		Other Coverage (Y/N)	Social Security Number		Date of birth (mo/day/yr)	
Name of Eligible Dependent children	Other Coverage (Y/N)	Social Security Number	Date of birth Mo/day/yr	Full-Time Student	Foster Child	Step Child

**C. Benefit Election: Check your election option below.**

I elect coverage for\*:

1. Myself only                       3. Myself, spouse and child(ren)  
 2. Myself and spouse                 4. Myself and child(ren)

I declare I am eligible to enroll in this plan and request to be covered. If the group provides that contributions be made by me, I authorize my employer to deduct them from my pay. All contributions for dependent medical, dental or vision premiums are done on a pre-tax basis unless I notify the Diocese in writing that I desire to have them deducted on an after tax basis. I hereby declare that, to the best of my knowledge and belief, the information given on this enrollment form is correctly recorded, complete and true.

\_\_\_\_\_ Date \_\_\_\_\_

**Signature of employee ACCEPTING COVERAGE** (do not print)  
 \*If you do not elect coverage for yourself and all eligible Dependents, read and complete Section D below.

**D. Refusal of Coverage Section**

I hereby acknowledge that I have been given an opportunity to apply for all insurance coverages for which I may be eligible under the policy sponsored by the Diocese. If I am not applying for all coverages for which I am eligible, I understand the benefits available under the plan and I **DECLINE** to enroll

myself    my spouse    my child(ren) for all coverage because \_\_\_\_\_

I UNDERSTAND if I refuse any coverage under the plan

(a) my Dependent(s) are not eligible for any coverage for which I am not insured.  
 (b) I (and/or my Dependents) will not be able to enroll in the plan later unless I have a qualifying event

\_\_\_\_\_ Date \_\_\_\_\_

**Signature of employee DECLINING COVERAGE** (do not print)

**E. Employer complete this section:**

Company name as it appears on your billing			Emp. Original Eff. Date	Delta Health Systems Completes
<b>DIOCESE OF MONTEREY</b>				Employee Effec. Date
Date employed	Occupation	Hrs. worked per week	Dep. Original Eff. Date	Dependent Effec. Date

Return to:  
 Diocese of Monterey  
 Benefits Department  
 P.O. Box 2048  
 Monterey, CA 93942-2048