DOW-R Dental Insurance

DOW-R Usage Loc#_________
Effective Date___________________
Date to BCBS ___________________
Date to DD ___________________
Invoice # ___________________ CR DB
Month(s) invoiced _____________
☐ Database ☐ Spreadsheet ☐ Census
☐ Sent to DOW-R controller

ENROLLMENT/CHANGE/WAIVE GROUP COVERAGE FORM A-1 FOR 9/1/20 – 12/31/21 PLAN YEAR

- **If waiving coverage, complete sections I and II**
- **If open enrollment and keeping same coverage, do nothing**
- **If enrolling or changing coverage (including special enrollment [qualifying event]), complete entire form except for section II**

I. Employee Information – must be completed for both enrolling and waivers **Group: Diocese of Winona-Rochester**

Effective Date	Coverage Selected ☐ Single ☐ Family	Coverage Level: ☐ $2,500 deductible ☐ $5,000 deductible	
Last Name	First Name	MI	Social Security Number
Address			
City	State	Zip	Home/Cell Telephone

Work E-mail address					Enrollment Status ☐ Benefit-eligible
Gender ☐Female ☐Male	Date of Birth *(mm/dd/yyyy)*	Age	Hire/Rehire Date *(mm/dd/yyyy)*	Hours Worked Per Week	☐ Special Enrollment: Event Date____/____/______ Reason: _______________________________________ Submit qualifying event documentation to location.

Summary of Benefits and Coverage – BlueCross BlueShield of Minnesota

A Summary of Benefits and Coverage (SBC) is available for medical plans only to assist you in understanding the details of the plan. A Uniform Glossary of insurance-related terms is also available. The SBC and/or the Uniform Glossary are accessible on the web at www.bluecrossmn.com or available free of charge when requested by contacting your employer or your employer's Agent or Broker, or by calling Customer Services at 1-800-382-2000 toll free.

II. Waiver of Coverage - Complete this section ONLY if you are declining coverage for you and /or your family members

I hereby acknowledge that I have been given the opportunity to participate in the group medical and dental plans provided by my employer. If I and/or any of eligible dependents desire to apply for this coverage at a later date, I may be required to wait until my group's renewal or until a special enrollment even occurs before coverage will be offered.

During open enrollment only - If you had coverage during August 2020 and are now waiving it, you are terminating/cancelling that coverage for you and your dependents effective 9/1/2020.

Special Enrollment Rights:
If you are declining enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order, you may be able to enroll yourself and your eligible dependents. In order to avoid claim delays, you should request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Special enrollment may also be available as a result of a marriage, provided that you request enrollment within 30 days after the marriage.

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Employee Signature - **Only Sign Here If You Are Waiving Coverage** Date

III. Dependent Information (If enrolling more than four dependents, please attach a separate sheet.) If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

*Social Security Numbers (SSN) for you and your dependents are requested but not required. If no SS, write N/A).

Relation	*Last Name*	*First Name*	*MI*	**Social Security Number*	*Gender*	*Date of Birth (mm/dd/yyyy)*	*Age*
Spouse					☐Male ☐Female		