

**Dodge City Diocesan Health Insurance Form**  
**October 1, 2011-September 30, 2012**

Please choose one.

\_\_\_\_\_ I am currently enrolled with the Diocese health insurance plan through Blue Cross Blue Shield of Kansas. Please complete Benefit Selection Form.

\_\_\_\_\_ I am currently enrolled with the Diocese health insurance plan through Blue Cross Blue Shield of Kansas, **and wish to make a change**. Please fill out change form and Benefit Selection Form.

\_\_\_\_\_ I wish to enroll in the Diocese health insurance plan through Blue Cross Blue Shield of Kansas. Please fill out enrollment form and Benefit Selection Form.

\_\_\_\_\_ I am waiving my rights to the Diocese health insurance plan with Blue Cross Blue Shield of Kansas. (Please complete the following information).

\_\_\_\_\_ I am covered by my spouse's or parent's insurance program.  
Spouse or Parent's name \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_

\_\_\_\_\_ I do not desire to enroll in Blue Cross Blue Shield of Kansas at this time and have no other insurance.

\_\_\_\_\_ Other (i.e. Medicaid, Medicare, CHAMPUS) \_\_\_\_\_

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**Notice of Enrollment Rights:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Check with your group administrator for details.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Employee Name \_\_\_\_\_  
(Please print your name)

Parish or School Name where employed \_\_\_\_\_