MEDICAL INSURANCE INFORMATION FORM

Please use this form for employee's enrollment, changes or termination. Complete both sides of this form and send or fax to:

MARY ANN SMIDA
EPISCOPAL DIOCESE OF CENTRAL PA
PO BOX 11937
HARRISBURG PA 17108-1937

PHONE: (717) 236-5959
FAX: (717) 236-2670

Employee Name: _____

Parish/City _____

Social Security No.: _____

Address: _____
Street County

_____
City State Zip

Telephone Number: _____ _____
Home Work

Date of Birth _____ Plan Type: ____ High Option PPO
____ EPO 90
____ PPO 90/70

Male: _____ Female: _____ Married: _____ Single: _____

Type of Activity:
Enrollment: _____Date of Employment: _____ Life Status Change _____

Change of Enrollment: _____ Date change Occurred: _____

Termination: _____ Last date of employment: _____

Employment Status: Active Full Time _____
Active Part Time _____
Retired _____
Number of Hours Worked Per Week: _____

_____ _____
Pay Type: Hourly Salary

Spouse: Name: _____ Male_____ Female_____
SS#: _____
Date of Birth _____

Dependents: Name: _____ Son _____ Daughter _____
SS#: _____
Date of Birth _____ Handicapped? Yes ___ No ___

Dependents: Name: _____ Son _____ Daughter _____
SS#: _____
Date of Birth _____ Handicapped? Yes___ No ___

Dependents: Name: _____ Son _____ Daughter _____
SS#: _____
Date of Birth _____ Handicapped? Yes ___ No ___

Dependents: Name: _____ Son _____ Daughter _____
SS#: _____
Date of Birth _____ Handicapped? Yes ___ No ___

OTHER INSURANCE COVERAGE:

Name of Subscriber: _____
Name of Insured: _____
ID/Policy Number: _____

MEDICARE:

Part A (Hospital): _____ Date: _____ Medical Claim #: _____

Part B (Medical): _____ Date: _____ Medical Claim #: _____

STUDENT:

Name: _____

Name of School/University: _____

Expected Date of Graduation: _____

Subscriber's Signature _____ Date: _____