

**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

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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: \_\_\_\_\_