ARCHDIOCESE OF CHICAGO

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2017 - 2018 EXTENDED HEALTH COVERAGE ENROLLMENT

An employee terminating for any reason (except when Medicare eligible at age 65 or older), a surviving spouse, under age 65 or children, or a divorced spouse who is enrolled in one of the health plans offered by the Archdiocese at the time of termination, death, or divorce may choose one of the following options with regard to his/her health benefits:

a. Extend medical coverage, at your own expense, for 18 months or until you become eligible for other group health coverage (including Medicare) not to exceed 18 months, OR

b. If the employee reaches age 65 and is ineligible to continue extended coverage, the dependent spouse under age 65 may continue for the remaining duration of 18 months, OR

c. Drop the insurance at the end of the month in which the termination, death, or divorce occurs.

Within 60 days of termination of coverage due to employment termination or change in benefit eligibility, you may extend your group coverage at your expense. Within 30 days termination of coverage due to death, dissolution of marriage, or dependent child's 26th birth date, eligible covered dependents may extend coverage at their own expense. Coverage is not automatically extended during this time, but rather becomes effective retroactively when the Human Resources office receives the Application Form and payment.

Surviving spouses and divorced spouses under age 55 at the time of enrollment in Extended Health are eligible to continue coverage for up to 24 months or until eligible for other insurance. Surviving spouses and divorced spouse over 55 can continue coverage until age 65 or until eligible for other insurance.

Please follow the instructions below. Please note that full-time employees transferred to non-eligible part-time status will also be eligible for extended health coverage.

NOTE: While on extended coverage, you will still be allowed to change plans and or type of coverage during the annual open enrollment period.

1. Complete the form, including your signature in section 1 as indicated.
2. Complete the Blue Cross and Blue Shield of Illinois Application and Policy Change ***only if:***
   a. the enrollee is a Dependent Child over 26
   b. the enrollee is a Divorced Spouse of employee or spouse of deceased employee
3. Attach your check for your payment of premium.
4. Return the check ***(payable to Catholic Bishop of Chicago)*** for the first month's premium and death certificate or divorce decree in case of death or divorce to:

Catholic Bishop of Chicago
Extended Health Coverage - HR
P.O. Box 1979
Chicago IL 60690

ARCHDIOCESE OF CHICAGO

2017 - 2018 EXTENDED HEALTH COVERAGE MONTHLY PREMIUMS

	SINGLE	FAMILY
BLUE CROSS BLUE SHIELD PPO	$728.00	$1,818.00
HMO ILLINOIS	$682.00	$1,472.00
BLUE ADVANTAGE HMO	$599.00	$1,293.00

Rates are subject to change on July 1st each year.

The Archdiocese of Chicago does not send monthly invoices. Premium payments for the upcoming months must be received before the 25th of each month. If payments are not received on time, your coverage may be terminated. The chart below is provided for your use in tracking your payments.

MONTH	DATE SENT	AMT	MONTH	DATE SENT	AMT	MONTH	DATE SENT	AMT
JAN.			JULY			JAN.		
FEB.			AUG.			FEB.		
MAR.			SEPT.			MAR.		
APR.			OCT.			APR.		
MAY			NOV.			MAY		
JUNE			DEC.			JUNE		

Please make checks payable to: CATHOLIC BISHOP OF CHICAGO

Please mail all forms and payments to:

Catholic Bishop of Chicago
Extended Health Coverage - HR
P.O. Box 1979
Chicago IL 60690

IF YOU HAVE ANY QUESTIONS
CALL HUMAN RESOURCES AT (312) 534-8209 or 5360.

TO TERMINATE COVERAGE - Submit in writing to the above address.

ARCHDIOCESE OF CHICAGO

ARCHDIOCESE OF CHICAGO EXTENDED HEALTH COVERAGE APPLICATION

Instructions: The employee, surviving spouse or children, or divorced spouse should complete the personal information requested below and mail this form along with a check for the first month's premium to Human Resources.

1 Personal Information (Please complete all fields)

Name _____Phone _____

Email _____

Address

_____

Street City, State, Zip

Birth Date _____/_____/_____ Social Security Number _____-_____-_____

Parish/School/Agency

_____

Signature _____ Date _____/_____/_____

2 Reason for Enrollment and Termination Date

(Please select the reason for enrollment in Extended Coverage)

☐ Termination of Employment

☐ Dependent Child over age 26

Date of Event
_____/_____/_____

☐ Employment status change to Non-Benefit Eligible

☐ Divorce / Spouse of Deceased Employee

(Please be sure to submit a death certificate or divorce decree)

3 Health Coverage Election

(Please indicate the plan you are selecting)

BCBS PPO	☐ Single	☐ Family
HMO Illinois	☐ Single	☐ Family
Blue Advantage	☐ Single	☐ Family

Effective Date _____/_____/_____

FOR OFFICE USE ONLY

MONTH	DATE RECD	AMT	MONTH	DATE RECD	AMT	MONTH	DATE RECD	AMT
JAN.			JULY			JAN.		
FEB.			AUG.			FEB.		
MAR.			SEPT.			MAR.		
APR.			OCT.			APR.		
MAY			NOV.			MAY		
JUNE			DEC.			JUNE		

Please make checks payable to: CATHOLIC BISHOP OF CHICAGO