Diocese of Ogdensburg
PO Box 369
Ogdensburg, NY 13669

DISABILITY INSURANCE
ENROLLMENT / CHANGE APPLICATION

IS THIS AN ENROLLMENT ☐ OR A CHANGE ☐

Effective Date:

Employer Information:

Name of Employer			Date of Hire	
Employer Street Address		City	State	Zip

Check all that apply: ☐ New Enrollment ☐ Name Change ☐ Address Change

Participant Information:

Last Name	First Name	Initial	Social Security Number
Street Address			County
City	State	Zip Code	Telephone Number
☐ Female ☐ Male	Date of Birth		

Participant Signature ______________________________ Date______________________

TO BE COMPLETED BY EMPLOYER

Is employee actively working full-time? ☐ Yes ☐ No Approximate number of hours employee works per year____________

Employer Authorizing Signature______________________________

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