# EMPLOYEE BENEFIT ENROLLMENT FORM

## SECTION 1: EMPLOYEE INFORMATION - *Complete every field below.*

| | | | |
|---|---|---|---|
| Name (Last, First, MI): | Social Security Number: | Birth Date: | Hire Date: |
| Permanent Address (Number, Street, Apt#): *no PO Box #* | City: | State: | Zip Code: |
| Email Address: | Cell Phone: | Salary Type: ☐ Hrly ☐ Salary<br>Employee Type: ☐ FT ☐ PT | Hrs/Wk: |
| Check All That Apply: ☐ Male ☐ Female ☐ Single ☐ Married | Do you have a spouse working for a Catholic school or parish? ☐ YES ☐ NO | | |
| Location Employed: | | Job Title: | |

## SECTION 2: QUALIFYING EVENT

☐ Open Enrollment ☐ Birth ☐ Divorce Date of Event: _____
☐ New Hire ☐ Death ☐ Loss of Other Coverage
☐ Part Time to Full Time ☐ Marriage ☐ Other _____ **Benefit(s) Effective:** _____

*SUMMARY OF BENEFITS & COVERAGES - ANNUAL NOTICES - ADDITIONAL INFORMATION AVAILABLE AT WWW.SFCATHOLIC.ORG/HUMAN-RESOURCES*

## SECTION 3: MEDICAL / PHARMACY / VISION *Current:*

| ***Continue Current Coverage*** | ***Waive Health Plan*** | ***Elect High Deductible Plan*** *Group#: HDHP 81448* | ***HSA* Health Savings Account (HDHP Plans only)*** | ***Elect Traditional Plan*** *Group#: TRAD 81448* | ***Elect Bronze Plan*** *Group#: BRNZ 81448* |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ Employee Only<br>☐ Employee + Child(ren)<br>☐ Family | Deduct per pay period:<br>$ | ☐ Employee Only<br>☐ Employee + Child(ren)<br>☐ Family | ☐ Employee Only<br>☐ Employee + Child(ren)<br>☐ Family |

*HSA limitations: Employees must be covered under a HDHP Plan. Employees cannot be enrolled in Medicare or any other health plan that is not a HDHP. Employees cannot be claimed as a dependent on another persons tax return. Employee's spouse cannot be enrolled in a general purpose FSA. The HSA will be set up to be effective the first day of the month after the date the enrollment form is signed. The HSA cannot be effective prior to the HDHP coverage date. There may be tax consequences if contributions exceed the annual IRS maximum. Employee and employer contributions will be applied to the annual IRS maximum. See the Employee Benefit Pricing form for information on the current IRS annual maximum.

**Coordination of Benefits:**
Will you or your dependents be covered by other health insurance in addition to the Diocesan Plan? ☐ Yes ☐ No
Do you currently have or have had other coverage within the last 18 months? ☐ Yes ☐ No

**If either question above is marked yes, please complete the following:**

| | | | | |
|---|---|---|---|---|
| Health Plan Name: | Carrier Phone: | Contract Holder Name: | ID #: | Group/Policy #: |
| Effective Date: | Cancel Date: | Medicare Card #: | Part A Effective Date: | Part B Effective Date: |

## SECTION 4: DENTAL PLAN *Group#:2437* *Current:*

Not all locations offer a dental plan, contact your local benefit coordinator for more information.

| ***Continue Current Coverage*** | ***Waive Dental Plan*** | ***Elect Employee Only Plan*** | ***Elect Family Plan*** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

By selecting a dental plan I understand that I am required to remain enrolled as a covered employee until the next open enrollment period, a qualifying event or until termination of employment. I understand that should I decide to apply for single coverage, even though I am eligible for family coverage, I cannot change my policy until open enrollment or a qualifying event.

## SECTION 5: DEPENDENT INFORMATION

Complete if you are newly enrolling/adding dependents to your current plan, or are dropping dependents from your current plan. A separate form is required to drop a spouse from your current plan. See your local benefit coordinator.

| ***Name (Last, First, MI)*** | ***Relationship*** | ***Sex*** | ***Date of Birth*** | ***Social Security Number*** | ***Medical*** *Current* | *Add* | *Drop* | ***Dental*** *Current* | *Add* | *Drop* | ***Totally Disabled*** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Y ☐ N ☐ |
| | | | | | | | | | | | Y ☐ N ☐ |
| | | | | | | | | | | | Y ☐ N ☐ |
| | | | | | | | | | | | Y ☐ N ☐ |
| | | | | | | | | | | | Y ☐ N ☐ |
| | | | | | | | | | | | Y ☐ N ☐ |
| | | | | | | | | | | | Y ☐ N ☐ |

**EMPLOYEE LAST NAME:** **EMPLOYEE FIRST NAME:**

*SUMMARY OF BENEFITS & COVERAGES - ANNUAL NOTICES - ADDITIONAL INFORMATION AVAILABLE AT WWW.SFCATHOLIC.ORG/HUMAN-RESOURCES*

## SECTION 6: LIFE INSURANCE WITH ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE *Current:*

Evidence of Insurability will be required, at my own expense, for any enrollment, or increase in coverage outside initial eligibility. UNUM reserves the right to reject such further applications. This plan has a continuation of coverage option in the event you leave employment. Contact UNUM for more information.

| *Continue Current Coverage* | *Waive Life and AD&D Plan* | *Level* | *Elect Life Plan Under Age 65* | *Elect Life Plan Over Age 65* | *Elect Life Plan Over Age 70* | *Elect Spouse Coverage* | *Elect Dependent Child Coverage* |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | *Class 1* | 10,000 ☐ | 6,500 ☐ | 5,000 ☐ | ☐ $2,000 | ☐ $1,000 per child $100 under 14 days |
| | | *Class 2* | 25,000 ☐ | 16,250 ☐ | 12,500 ☐ | | |
| | | *Class 3* | 35,000 ☐ | 22,750 ☐ | 17,500 ☐ | | |
| | | *Class 4* | 50,000 ☐ | 32,500 ☐ | 25,000 ☐ | | |

***Beneficiary Designation :*** *Complete for a new enrollment, or when making a beneficiary change.*

| *First Beneficiary(ies):* | *Relationship* | *Birth Date* | *Social Security #* | *Benefit %* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| *Contingent Beneficiary(ies):* | | | | |
| | | | | |
| | | | | |

## SECTION 7: LONG TERM DISABILITY *Current:*

Evidence of Insurability, at my own expense, will be required for any enrollment or increase in coverage outside initial eligibility. UNUM reserves the right to reject such further applications. Level of coverage is based upon monthly salary.

| *Continue Current Coverage* | *Waive LTD Plan* | *Elect Level 1 $0—2,000* | *Elect Level 2 $2, 001—3,000* | *Elect Level 3 $3,001—$5,000* | *Elect Level 4 $5,001— 8,334* | *Elect Level 5 $8,335—up* | *Estimated Annual Salary* (*required if electing coverage*) |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | $ |

## SECTION 8: SPECIAL ENROLLMENT PROVISIONS

**Loss of Other Coverage**: If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other insurance or group plan coverage is in effect, you may be able to enroll yourself and your dependents in a diocesan plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
**Loss of Medicaid or SCHIP:** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while on Medicaid or SCHIP you may be able to enroll yourself and your dependents in a diocesan plan if you or your dependents lose eligibility of that coverage. However, you must request enrollment within 60 days after you or your dependents lose that coverage.
**New Dependent by Marriage, Birth, Adoption, or Placement for Adoption**. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
**Eligibility for Premium Assistance under Medicaid or CHIP.** If the current employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or Children's Health Insurance Program (CHIP), you may be able to enroll yourself and your eligible dependents. You must request enrollment within 60 days.
**COBRA Continuation of Coverage.** COBRA can become available to you and other members of your family when group coverage would otherwise end. After a qualifying event, COBRA is offered to each person on your plan who is a 'qualified beneficiary'. If you or a family member elects COBRA, you are responsible for paying the full cost of the continued coverage
***IMPORTANT: THIS FORM MUST BE COMPLETED AND ON FILE WITH YOUR EMPLOYER OR THE SPECIAL ENROLLMENT PERIOD DESCRIBED ABOVE WILL NOT APPLY.***

## SECTION 9: AUTHORIZATION

By signing below, I agree that I have read, understand and completed all of the information as outlined in this form. I understand that to be eligible for benefits, I must be working a minimum of 20 hours per week, year round (1040 hrs/yr). As a NEW EMPLOYEE I understand that eligible benefits begin the first day of the month after 30 days of employment. As a CURRENT EMPLOYEE I understand that eligible benefits begin the first day of the month after a qualifying life event. All applicable premiums will be deducted as pre-tax unless I notify my Payroll Office otherwise. I understand that this form must be completed and returned within the first 30 days of employment or I forfeit eligibility until the next open enrollment period. I understand that if I have made any false statements or misrepresentations or have failed to disclose or concealed any material fact, the plans will be entitled to deny benefits. I hereby authorize payments directly to the provider of service by my employer's benefit plans herein named of the group benefits payable to me. I understand I am financially responsible for charges not covered by this assignment. I hereby authorize release, to or by the plan, of any hospital, medical, or other insurance information concerning myself or any of my dependents which may be required to process my claim. A photocopy of this authorization may be honored. I hereby request the amount(s) for coverage for which I am or may become eligible, and hereby authorize my employer to deduct the required contribution, if any, from my earnings.

**EMPLOYEE SIGNATURE** **DATE SIGNED**