CATHOLICCARE
AUTHENTICALLY CATHOLIC

Employee Benefits Enrollment / Change Form

Local Benefit Coordinator use only:			
NEW	CHANGE	NO CHANGE	ALL WAIVE

Benefit Effective Date:

☐ Open Enroll	☐ Birth	☐ Marriage
☐ New Hire	☐ Death	☐ Divorce
☐ Pt to Ft	☐ Loss of Coverage	☐ Other

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

EMPLOYEE INFORMATION *(Complete every field)*

Name (Last, First, MI): ***Date of Birth***: ***Social Security Number***:

Permanent Address (Number, Street, Apt#): *no PO Box #* ***City***: ***State***: ***Zip Code***:

Personal Email Address: ***Cell Phone***: **Sex**: ☐ Male ☐ Female ***Marital Status***: ☐ Single ☐ Married

Location Employed: ***Job Title***: ***Date of Hire***:

Is your spouse working in a diocesan entity? ☐ Yes ☐ No ***Salary Type***: ☐ Hrly ☐ Salary ***Scheduled Wkly Hrs***: ***Employee Type***: ☐ FT ☐ PT

HEALTH PLAN OPTIONS *The CatholicCare Health Plan includes Pharmacy Coverage.*

My Current Health Enrollment:

Continue My Current Plan: ☐

Waive Health Plan: ☐

I want to Elect / Change my Health Plan Enrollment:

Please select plan tier. If plan election includes dependents, please list below.

High Deductible Plan	☐ Employee Only	☐ Family	☐ Employee + Child(ren)
Traditional Plan	☐ Employee Only	☐ Family	☐ Employee + Child(ren)
Basic Plan	☐ Employee Only	☐ Family	☐ Employee + Child(ren)

I am currently or choosing to enroll in the High Deductible Health Plan. Please deduct the following amount from my paycheck to be put into my HSA Account.

My Total HSA deduction each Pay Period: _____ **or Total per Month:** _____

Health Savings Account (HSA): If enrolled in the High Deductible Health Plan (HDHP), you may be eligible to participate in the Health Savings Account. To be eligible, you cannot be enrolled in Medicare or any other health plan that is not a High Deductible Health Plan. You cannot be claimed as a dependent on another persons tax return. Your 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 insurance coverage date. There may be tax consequences to you if your contributions exceed the annual IRS maximum. Employee and employer contributions are applied to the annual IRS maximum. See the Plan Pricing Sheet provided by your location for information on employer contribution amounts and the annual IRS Maximum.

Coordination of Benefits:

Will you or one of your covered dependents be enrolled in other health insurance in addition to CatholicCare? ☐ NO ☐ YES - If 'YES', complete the following:

Health Plan Name:	Carrier Phone:	Contract Holder Name:	ID #:
Effective Date:	Cancel Date:	Medicare Card #:	Part A Effective Date:

DEPENDENT INFORMATION

Complete if you are newly enrolling or adding dependents to your current plan, or you 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
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											☐ Y ☐ N

EMPLOYEE NAME:

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LIFE / AD&D PLAN OPTIONS

Evidence of Insurability will be required, at your 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. If you mark 'continue current plan' your beneficiaries will remain the same unless you indicate differently below. **Coverage Level for each Class is based on your current age and is adjusted at the appropriate birthday**.

My Current Life Enrollment:

Continue My Current Plan: ☐

Waive Life Plan: ☐

I elect to include additional coverage for my:

☐ **Spouse** ☐ **Dependent**

I want to Elect / Change my Life Enrollment

I am:	*Under Age 65*	*Age 65 to 69*	*Age 70 +*
Class 1 Coverage	☐ 10,000	☐ 6,500	☐ 5,000
Class 2 Coverage	☐ 25,000	☐ 16,250	☐ 12,500
Class 3 Coverage	☐ 35,000	☐ 22,750	☐ 17,500
Class 4 Coverage	☐ 50,000	☐ 32,500	☐ 25,000

Life Insurance Beneficiary Designation: *To confirm beneficiaries, we encourage you to complete/verify at each open enrollment.*

Name of First Beneficiary(ies):	***Relationship***	***Date of Birth***	***SS #***	***Benefit %***
Name of Contingent Beneficiary(ies):				

LONG TERM DISABILITY PLAN OPTIONS

Evidence of Insurability will be required at your own expense for any enrollment or increase in coverage outside initial eligibility. UNUM reserves the right to reject such further applications. ***Coverage level is based upon average monthly salary and reviewed annually***.

My Current LTD Enrollment:

Continue Current Plan: ☐

Waive LTD Plan: ☐

I want to Elect / Change my LTD Enrollment:

	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
LTD Plan Electing:	☐	☐	☐	☐	☐
My Average Monthly Salary:	($0 – $2,000)	($2,001 – $3,000)	($3,001 – $5,000)	($5,001 – $8,334)	($8,335 +)

DENTAL PLAN OPTIONS

Not all locations participate in the Dental Plan. Please contact your local coordinator for more information. By selecting a dental plan, you understand that you are required to remain enrolled as a covered employee until the next open enrollment period, qualifying event or until termination of employment. You understand that by applying for single coverage at this enrollment period, even though you are eligible for family coverage, you cannot change your policy until the next open enrollment period or qualifying event.

My Current Dental Plan Enrollment:

Continue My Current Plan: ☐

Waive Dental Plan: ☐

I want to Elect / Change my Dental Plan Enrollment:

Please select plan tier. If plan election includes dependents, please list on Page 1.

☐ **Employee Only** ☐ **Family**

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 CatholicCare 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 CatholicCare 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. Continuation of Coverage. CatholicCare is intended to be a "church plan" as defined in Code Section 414(e) and Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). CatholicCare is not subject to Title I of ERISA, including Part 6 of Title I which provides for continuation of health care coverage upon the occurrence of certain events. To the extent that any of the continuation of coverage provisions described in this notice are identical to the requirements of Part 6 of ERISA Title I, the inclusion of such provisions reflects the unilateral decision of CatholicCare to do so. CatholicCare reserves the right to modify the continuation of coverage provisions of the Plan in the future, as long as the provisions so modified meet the requirements of other applicable law. *IMPORTANT: THIS FORM MUST BE COMPLETED AND ON FILE WITH CATHOLICCARE OR THE SPECIAL ENROLLMENT PERIOD DESCRIBED ABOVE WILL NOT APPLY.*

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**