



Business Offices please fax completed forms to Human Resources Office at Pastoral Center at 214.379.3224

Event Type:					
<input type="checkbox"/> New Hire Date of Hire: ___/___/___	<input type="checkbox"/> Address Change	<input type="checkbox"/> Termination of Employment Effective Date: ___/___/___	<input type="checkbox"/> Qualifying Event (Ex: marriage, birth, adoption, death, loss of other coverage, reduction in hrs., dependent max age, Medicare entitlement) Type of Event: _____ Effective Date: ___/___/___		
Name:		Date of Birth		Phone:	
Location:		Social Security #:		Salary:	
Home Address:		Classification:	<input type="checkbox"/> Lay Employee	Gender:	
			<input type="checkbox"/> School Employee	Is Your Spouse Employed with the Diocese?	Y or N
<input type="checkbox"/> Nun					
<input type="checkbox"/> Priest					
<input type="checkbox"/> Retired Priest					
<input type="checkbox"/> Seminarian					

Please mark your selections in the box provided to the right of each section.

MEDICAL/DENTAL

Medical Insurance	Employee Only	Employee + Spouse	Employee + Child	Employee + 2 or more Children	Family	2011 Medical / Dental Option Selected
2011 Plan Options	Your Cost	Your Cost	Your Cost	Your Cost	Your Cost	<input type="checkbox"/> Medical <input type="checkbox"/> DHMO Dental <input type="checkbox"/> PPO Dental
Medical	\$0	\$410	\$346	\$458	\$704	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + 2 or more Children <input type="checkbox"/> Family <input type="checkbox"/> Waive Medical Coverage – proof of other coverage is required <input type="checkbox"/> Waive Dental Coverage
DHMO Dental	\$0	\$16	\$15	\$15	\$29	
PPO Dental	\$24	\$63	\$59	\$66	\$82	

OTHER EMPLOYER-PAID INSURANCE FOR THE EMPLOYEE

- ✓ Employee Basic Life and AD&D Insurance coverage is provided at no cost to you equal to 1 times your Annual Compensation (maximum \$50,000/minimum \$20,000).
- ✓ Employee Short-Term Disability coverage at 60% of your salary (maximum benefit \$1,000/week)

LIFE/AD&D - DESIGNATION OF BENEFICIARY

This beneficiary election is effective as of the signature date on this form. This designation applies to the Basic Life and AD&D paid by your employer and any Employee Voluntary Life election. The Employee is the beneficiary for any voluntary spouse or dependent life insurance.

Primary Beneficiary	First & Last Name	Social Security Number	Home Address	Relationship	Date of Birth	Percentage
1.						
2.						
Contingent Beneficiary	First & Last Name	Social Security Number	Home Address	Relationship	Date of Birth	Percentage
1.						
2.						

CURRENT DEPENDENT INFORMATION – complete dependent information and indicate coverage with an X for each dependent

Dependent Information & Coverage Elections							
Relation ship	Name	Date of Birth	Social Security (REQUIRED)	Gender	Medical & PPO Dental	Medical & DHMO Dental	DHMO Dental election requires Primary Care Dentist ID# & Name
							To elect a DHMO dentist, call Aetna at 1-877-238-6200.

The following benefits are NOT available for enrollment until the next annual enrollment period to be effective next calendar year. If you are experiencing a qualifying event, you may drop the following coverage(s) but not make any other changes to that coverage.

VOLUNTARY LIFE INSURANCE:

Employee Coverage	Spouse Coverage	Dependent Child Coverage
<input type="checkbox"/> I elect to drop my coverage for employee voluntary life due to a qualifying event and understand that if I enroll at a later time, I may be subject to health questions in order to be approved for coverage.	<input type="checkbox"/> I elect to drop my coverage for spouse voluntary life due to a qualifying event and understand that if I enroll at a later time, I may be subject to health questions in order to be approved for coverage.	<input type="checkbox"/> I elect to drop my coverage for dependent child voluntary life due to a qualifying event and understand that if I enroll at a later time, I may be subject to health questions in order to be approved for coverage.

VOLUNTARY LONG TERM DISABILITY:

<input type="checkbox"/> I elect to drop my Voluntary Long Term Disability coverage due to a qualifying event and understand that if I enroll at a later time, I may be subject to health questions in to order to be approved for coverage.
--

FLEXIBLE SPENDING ACCOUNTS:

Medical Flexible Spending Account	<input type="checkbox"/> I elect to drop my Medical FSA due to a qualifying event
Dependent Care Flexible Spending Account	<input type="checkbox"/> I elect to drop my Dependent Care FSA due to a qualifying event

VOLUNTARY VISION:

<input type="checkbox"/> I elect to drop my current coverage for voluntary vision due to a qualifying event based on the following tier: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child or Children <input type="checkbox"/> Family

This statement is not a plan document or a contract. I hereby authorize payroll deductions for the coverage(s) I have selected. I understand that I cannot make changes to my elections until the next annual enrollment period unless I have a qualifying event.

Signature _____

Date _____

Retain a copy for your records and return completed form to the Business Office at your location.
Enrollment deadline for new hires and qualifying events is 31 days from the event.