ROMAN CATHOLIC DIOCESE OF DALLAS

2018 Enrollment Form

New Hire/Termination/Qualifying Event/Change Form

Costs shown are Monthly.

Business Offices: Please fax completed form to Human Resources office at ***Pastoral Center (214) 379-3224 or scan to hr@cathdal.org***

Event Type:			
☐ **New Hire** Date of Hire: ___ / ___ / ___	☐ **Address Change**	☐ **Termination of Employment** Effective Date: ___ / ___ / ___	☐ **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:		**Soc. Sec. # :**		**Email:**	
Home Address:		**Classification:**	☐ Church/Lay Employee ☐ School Employee ☐ Nun ☐ Priest ☐ Retired Priest ☐ Seminarian	**Gender:** F M **Salary:**	
				Is Your Spouse Employed with the Diocese?	Y or N

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	2018 Medical / Dental Option Selected
2018 Plan Options	Your Cost	Your Cost	Your Cost	Your Cost	Your Cost	☐ **Medical** ☐ **DHMO Dental** ☐ **PPO Dental**
Medical	$0	$560	$473	$626	$964	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Employee + 2 or more Children ☐ Family ☐ Waive Medical Coverage – **proof of other coverage is required** ☐ Waive Dental Coverage
DHMO Dental	$0	$19	$19	$19	$34	
PPO Dental	$34	$87	$81	$90	$109	

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.						

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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	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 one of the following coverage but not make any other changes to that coverage.

VOLUNTARY LIFE INSURANCE:

Employee Coverage	*Spouse Coverage*	*Dependent Child Coverage*
☐ 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.	☐ 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.	☐ 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:

☐ 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:

Flexible Spending Account	2018 Flexible Spending Account
Medical Flexible Spending Account	☐ I elect to drop my Medical FSA due to a qualifying event
Dependent Care Flexible Spending Account	☐ I elect to drop my Dependent Care FSA due to a qualifying event

VOLUNTARY VISION:

☐ **I elect to drop my current coverage for voluntary vision due to a qualifying event based on the following tier:**

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child or Children ☐ Family

The above information is true to the best of my knowledge. I authorize my contributions to be payroll deducted pre-tax for all benefit elections with the exception of voluntary life insurance and voluntary long term disability. Payroll deductions for voluntary life insurance and voluntary long term disability will be deducted post tax. I understand that if I waive medical insurance, I also waive Short Term Disability and Life Insurance. I understand that if I do not elect voluntary coverage(s) at this time for myself and my eligible dependents, I waive my right to enroll for coverage(s) during the calendar year. I understand that I cannot make changes to my elections until the next annual enrollment period unless I have a qualifying event. I consent to receive electronic communications about the Diocese Health Plan at my work email and/or the email address furnished on this form. I understand confidential information may be disclosed to third parties in connection with the administration of this plan and is protected according to the applicable law. I understand that my dependents must be enrolled in the medical plan to be eligible and participate in any other benefit offered.

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.

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