



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

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:		Soc. Sec. # :		Email:		
Home Address:		Classification:	<input type="checkbox"/> Church/Lay Employee	Gender:	F M	Salary:
			<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	2019 Medical / Dental Option Selected
2019 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	\$571	\$482	\$639	\$983	<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	\$19	\$19	\$19	\$35	
PPO Dental	\$35	\$89	\$83	\$92	\$111	

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	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
<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.
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FLEXIBLE SPENDING ACCOUNTS:

Flexible Spending Account	2019 Flexible Spending Account
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

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.