Complete and return this form only if you are requesting changes or if you are enrolling in flexible spending for 2019.
Enrollment ends 10/31/2018.

Catholic Diocese of Dallas
2019 OPEN ENROLLMENT FORM

EMPLOYEE INFORMATION (VERIFY INFORMATION & COMPLETE BLANK SECTIONS)

Employee Name:		Classification: (Please check box)	❑ Church/ Lay Employee ❑ School Employee ❑ Nun ❑ Priest ❑ Retired Priest ❑ Seminarian
Address:			
Location:	Date of Birth:	Date of Hire:	Gender:
Phone:	Email:	Spouse Employed w/Diocese? ❑ Y ❑ N	❑ M ❑ F

MEDICAL / DENTAL

No change to my Medical coverage for 2019 ❑

No change to my Dental coverage for 2019 ❑

Check the box to indicate the coverage you elect for medical and dental. Please include dependent information in the section below.

Medical Plan Your Cost Per Month	❑ Employee Only $0.00	❑ Employee + Spouse $571	❑ Employee + 1 Child $482	❑ Employee + 2 or more Children $639	❑ Employee + Family $983	❑ Waive Medical Coverage – proof of other coverage is required
DHMO Dental Plan Dental Plan Election Your Cost Per Month	❑ Employee Only $0.00	❑ Employee + Spouse $19	❑ Employee + 1 Child $19	❑ Employee + 2 or more Children $19	❑ Employee + Family $ 35	❑ Waive Dental Coverage
PPO Dental Plan Dental Plan Election Your Cost Per Month	❑ Employee Only $35	❑ Employee + Spouse $89	❑ Employee + 1 Child $83	❑ Employee + 2 or more Children $92	❑ Employee + Family $111	

DEPENDENT INFORMATION & COVERAGE ELECTIONS (INDICATE COVERAGE ELECTION WITH AN "X")

Relation ship	Name	Date of Birth	SSN (required)	Gender	Medical	PPO Dental	DHMO Dental	DHMO requires Primary Care Dentist ID & Name	Voluntary Life	Voluntary Vision
					❑	❑	❑	For new DHMO dentist elections, call Aetna at 1-877-238-6200. Current dentist elections will rollover.	❑	❑
					❑	❑	❑		❑	❑
					❑	❑	❑		❑	❑
					❑	❑	❑		❑	❑
					❑	❑	❑		❑	❑

LIFE INSURANCE

Employees enrolled in the medical plan are also enrolled in employer paid life insurance coverage and short-term disability at no additional cost

Designation of Beneficiary for Employer Paid Life Insurance and any Employee Voluntary Life Insurance if elected. The employee is the beneficiary for any voluntary spouse or dependent life insurance.

No change to my Beneficiary for 2019 (check box) ❑

Primary Beneficiary Full Name	SSN	Address	Relationship	Birthdate	Percentage
1.					%
2.					%
Secondary Beneficiary Full Name	**SSN**	**Address**	**Relationship**	**Birthdate**	**Percentage**
1.					%
2.					%

See Reverse Side

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VOLUNTARY LIFE INSURANCE (AD&D included for Employee coverage)

EMPLOYEE	EOI Required: Yes, over 200k		**SPOUSE**	EOI Required: Yes, over 30k		**DEPENDENT**	EOI Required: Yes, may be required under certain circumstances	
❑ No Change			❑ No Change			❑ No Change		
Coverage	Cost	2019 Election	Coverage	Cost	2019 Election	Coverage	Cost	2019 Election
$25,000	See separate rate and calculation page for voluntary coverage. Rate page can be obtained from the Diocese HR website or your Business Manager.	❑	$25,000	See separate rate and calculation page for spouse voluntary coverage. Rate page can be obtained from the Diocese HR website or your Business Manager.	❑	$2,000	$0.62	❑
$50,000		❑	$30,000		❑	$4,000	$1.24	❑
$75,000		❑	$50,000		❑	$6,000	$1.86	❑
$100,000		❑	$75,000		❑	$8,000	$2.48	❑
$125,000		❑	$100,000		❑	$10,000	$3.10	❑
$150,000		❑	$125,000		❑	Waive Dep Vol Life		❑
$200,000		❑	$150,000		❑	---	---	
$250,000		❑	$200,000		❑	---	---	
$300,000		❑	$250,000		❑	---	---	
$350,000		❑	Waive Spouse Vol Life		❑	---	---	
$400,000		❑	---	---		---	---	
$450,000		❑	---	---		---	---	
$500,000		❑	---	---		---	---	
Waive Employee Vol Life/AD&D		❑	---	---		---	---	

VOLUNTARY LONG TERM DISABILITY

(COST AND BENEFIT BASED ON SALARY AS OF 1/1/17, THEREFORE, IF YOU HAD A SALARY INCREASE IN 2018, YOUR COST AND BENEFIT AMOUNTS COULD BE SLIGHTLY DIFFERENT THAN AMOUNTS SHOWN)

EOI Required: No, if hired in 2018		❑ No Change
LTD Monthly Benefit: *(if elected)*	LTD Monthly Cost:	❑ Elect LTD ❑ Waive LTD

VOLUNTARY VISION

(RATE CHANGES FOR 2019)

❑ No Change

Vision Plan	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Child (ren)	❑ Employee + Family	❑ Waive Vision Coverage
Your Cost Per Month	$6.43	$12.22	$12.86	$18.91	

FLEXIBLE SPENDING ACCOUNTS (MUST RE-ENROLL ANNUALLY – DOES NOT CARRY FORWARD)

Health Care Flexible Spending *(annual max $2,400, min $240)*	❑ Elect - $_______________ Annual Contribution	❑ Waive
Dependent Care Flexible Spending *(annual max $5,000, min $240)*	❑ Elect - $_______________ Annual Contribution	❑ Waive

ACKNOWLEDGE AND SIGN

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 current calendar year 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.

_______________________________________ _______________________

Employee signature *Date*

Retain a copy for your records and return completed form to the Business Office at your location.

Enrollment deadline for 2019 benefits is 10/31/2018.

Watch your mailbox for your benefit confirmation statement coming in late November.

See Reverse Side