2017 Medical & Dental Benefits Enrollment or Change Form

Diocese of California
Group # 0086 Medical Billing Unit: 805
1055 Taylor St. San Francisco, CA 94108

☐ New Hire **OR** ☐ Mid-Year Status Change & New Enrollment **OR** ☐ New Enrollment of Existing Benefit Eligible Employee
(be sure to send cover page with details of qualifying event & check appropriate boxes below for adding or deleting dependents)

Hire Date: _____ Change of Status Date:_____ Ins Coverage Effective Date:_____*

*Ins. effective date is the 1st of the month following date of hire or qualifying event date.
Eligible retroactive adjustments can be made effective the 1st of the month within 60 days

PRIMARY MEMBER'S PERSONAL INFORMATION (please respond to all items)

Name:_____ Personal Email:_____

Social Security #: _____ Date of Birth: _____ Gender: _____

Home Address:_____

City, State, Zip: _____

2017 Annual Salary: _____ Home/Cell Phone: (_____)_____

Marital/Partner Status ***(circle one):*** Single Married State Registered Domestic Partnership

Benefit Elections (check the box & circle the level of coverage of your selection)

Monthly Premiums:	Single	Dual	Family
☐ Kaiser EPO 80	**$621.15**	**$1,118.28**	**$1,739.43**
☐ Kaiser EPO High (new plan eff 1/1/17)	**$795.40**	**$1,431.93**	**$2,227.33**
☐ BlueCross/Blue Shield PPO 80/60	**$831.28**	**$1,496.50**	**$2,327.78**
☐ Blue Cross/Blue Shield EPO 90	**$879.45**	**$1,582.60**	**$2,466.15**
☐ *I decline **medical** coverage at this time and have completed & attached the waiver of coverage*			
☐ Cigna Dental	**$67.65**	**$121.98**	**$189.63**
☐ *I decline **dental** coverage at this time and have completed & attached the waiver of coverage*			

Dependent Information (list those to be added or removed from medical & dental coverage)

Children, up to age 30, may be enrolled in our plans. See employer for cost share policies*. If you wish to enroll one or more dependents please list them below, use additional page if necessary.

	Names	Date of Birth	Social Security #	Gender	Circle Add (+) or Delete (-)	
Partner/Spouse:				M / F	**+ / -** Med	**+ / -** Dental
Child(ren):				M / F	**+ / -** Med	**+ / -** Dental
				M / F	**+ / -** Med	**+ / -** Dental
				M / F	**+ / -** Med	**+ / -** Dental
				M / F	**+ / -** Med	**+ / -** Dental

Authorizing Information

Employee Status = (circle one)
Estimated average hours scheduled per week

20 - <30 hrs/wk

Premiums billed to employer but medical or dental may be the responsibility of employee. To set up PR deductions for any/all health ins premiums contact DioCal PR office for the form

30 or more hrs/wk

At minimum, Kaiser EPO 80 is paid in full by employer. Check with employer on cost-share policy for higher cost plans. Premiums can be processed at pre-tax PR deductions

Employee's Signature & Date: _____

Employing Entity Name, City & Parish Code:_____

Employer Authorizing Name & Signature:_____

Authorizing agent's contact info (phone/fax/email):_____

Keep original documents in personnel file on site.
Return a copy of the completed form to Sarah Crawford, Benefits Coordinator
Fax: 415-673-4863 or Email: sarahc@diocal.org
Mail: 1055 Taylor St. SF, CA 94108