Medical & Dental Benefits
Open Enrollment / Change Form

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

☐ Open Enrollment

Coverage Effective Date:__**Jan 1, 2017**___*

*Ins. effective date is the 1st of the month following date of hire.
Retroactive new or changes can be made to 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*. 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

*Depending upon employing entity's cost share policy, the employee may be responsible for premiums for children ages 25+ or 19+ if not a full-time student. Please contact DioCal Benefits Administrator to clarify employer's cost share policy, email: sarahc@diocal.org or ph: 415-869-7805

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

 office use only: ☐MLPS__________ ☐EBDB__________ ☐PR__________