

# 2018 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, 2018** \*

\*Ins. effective date is the 1<sup>st</sup> of the month following date of hire. Retroactive new or changes can be made to the 1<sup>st</sup> 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: \_\_\_\_\_

2018 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
<input type="checkbox"/> Kaiser EPO 80		<b>\$695.95</b>	<b>\$1,252.55</b>	<b>\$1,949.55</b>
<input type="checkbox"/> Anthem BlueCross/Blue Shield PPO 80/60		<b>\$889.70</b>	<b>\$1,601.05</b>	<b>\$2,490.75</b>
<input type="checkbox"/> Kaiser EPO High		<b>\$890.73</b>	<b>\$1,603.10</b>	<b>\$2,493.83</b>
<input type="checkbox"/> Anthem BlueCross/Blue Shield EPO 90		<b>\$936.85</b>	<b>\$1,686.13</b>	<b>\$2,622.98</b>
<input type="checkbox"/> I decline <b>medical</b> coverage at this time and have completed & attached the waiver of coverage				
<input type="checkbox"/> Cigna Dental		<b>\$ 72.78</b>	<b>\$131.20</b>	<b>\$203.98</b>
<input type="checkbox"/> I decline <b>dental</b> 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](mailto:sarahc@diocal.org)  
Mail: 1055 Taylor St. SF, CA 94108