2019 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:_____________________*
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: ____

2019 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	**$775.93**	**$1,397.08**	**$2,173.00**
☐ Anthem BCBS BlueCard PPO 80	**$841.53**	**$1,514.95**	**$2,356.48**
☐ Anthem BCBS BlueCard PPO 90	**$927.63**	**$1,669.73**	**$2,597.35**
☐ Kaiser EPO High	**$975.80**	**$1,756.85**	**$2,732.65**

☐ *I decline **medical** coverage at this time and have completed & attached the waiver of coverage*

	Single	Dual	Family
☐ Cigna Dental/Ortho	**$ 74.83**	**$134.28**	**$209.10**

☐ *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: ____

Employer Authorizing Name & Signature:____

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

 office use only: ☐MLPS__________________ ☐EBDB______________________ ☐PR__________________