2021 Medical & Dental Benefits
Annual Enrollment Form New or Change

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

☐ Annual Enrollment

Coverage Effective Date: **Jan 1, 2021** *

*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: _____

(circle): **Home** or **Cell** Ph: (____) _____ Work Ph: (____) _____

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
Medical Plan:				
	☐ Kaiser EPO 80	**$880.48**	**$1,584.65**	**$2,465.13**
	☐ Anthem BCBS BlueCard PPO 80	**$936.85**	**$1,686.13**	**$2,622.98**
	☐ Anthem BCBS BlueCard PPO 90	**$1,032.18**	**$1,858.33**	**$2,890.50**
	☐ Kaiser EPO High	**$1,090.60**	**$1,962.88**	**$3,053.48**
	☐ *I decline **medical** coverage at this time (consult with employer who may offer a benefit waiver allowance)*			
Dental Plan:				
	☐ Cigna Dental/Ortho	**$ 78.93**	**$142.48**	**$221.40**
	☐ *I decline **dental** coverage at this time (consult with employer who may offer a benefit waiver allowance)*			

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_____