2024 Medical & Dental Benefits Enrollment Form

Diocese of California
Group # 0086 Medical Billing Unit: 805

☐ New Employee: date of hire / first day of work: _____ Coverage Effective date: ____ 1, 2024 *
*Ins. effective date is the 1st of the month following date of hire, or immediately if hire date is 1st of the month. Retroactive coverage can be made to the 1st of the month within 60 days

☐ Existing employee making changes *

* Detail Qualifying Life Event & event date: _____ Coverage Effective: ____ 1, 2024*
*Ins. effective date is the 1st of the month following QLE. Retroactive coverage can be made to the 1st of the month within 60 days

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

Legal Name *(last)*: _____ Legal Name *(first)*: _____

Social Security #: _____ Date of Birth (mm/dd/yy): _____ Gender: F or M

Preferred Mailing Address: _____

City: _____ State: _____ ZIP: _____

Mobile Ph: (____) _____ Work Phone: (____) _____

Personal Email: _____ **Work** Email: _____

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

Medical Plan:

Monthly Premiums:	Single	Dual	Family
☐ Kaiser EPO 80	**$1,021**	**$1,838**	**$2,859**
☐ Anthem BCBS BlueCard PPO 80	**$1,087**	**$1,956**	**$3,042**
☐ Anthem BCBS BlueCard PPO 90	**$1,196**	**$2,154**	**$3,350**
☐ Kaiser EPO High	**$1,265**	**$2,277**	**$3,541**

☐ *I decline **medical** coverage at this time and have provided the appropriate waiver of coverage to my employer. I understand that I may enroll mid-year by submitting revised enrollment form within 30days of a Significant Life Event (SLE) or opt in during Annual Enrollment for coverage effective 1/1/25*

Dental Plan:

☐ Delta Dental Premium	**$79**	**$142**	**$221**

☐ *I decline **dental** coverage at this time and have provided the appropriate waiver of coverage to my employer. I understand that I may enroll mid-year by submitting revised enrollment form within 30days of a Significant Life Event (SLE) or opt in during Annual Enrollment for coverage effective 1/1/25*

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 (Last, First)	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 Authorized (name/sign, contact # or email): _____

Keep original documents in personnel file on site.
Return a copy of the completed form to Sarah Crawford, Benefits Coordinator
Send PDF by Email: sarahc@diocal.org
office use only: ☐MAP _____ ☐EBDB _____