DIOCESE OF PENSACOLA-TALLAHASSEE

BENEFIT ELECTION FORM 2018-2019

PLEASE CHECK WHICH APPLIES:

1) OPEN ENROLLMENT 2018 ☐ 2) CHANGE OF STATUS ☐ 3) NEW HIRE ENROLLMENT ☐

A. EMPLOYEE INFORMATION

First Name	Last Name	M.I.	Social Security #	Birth Date	Gender	Home Phone

Street Address	Apt #	City	County	State	Zip Code

Job Title	Work Location	Location #	Date of Hire

B. MEDICAL– Meritain Health

These are **monthly** payroll deductions withheld on a **pre-tax basis**

Select One Option	Standard Plan	HDHP Plan
Employee Only	☐ $ 80.12	☐ $ 18.38
Employee + Spouse	☐ $ 534.90	☐ $ 303.64
Employee + Child(ren)	☐ $ 447.02	☐ $ 232.24
Employee + Family	☐ $ 696.44	☐ $ 359.20
DECLINE	☐ I have other Medical Coverage (Proof of other coverage must be sent to HR Department or you will automatically be enrolled in the HDHP Plan.)	

C. DENTAL– Delta Dental

D. VISION – VSP

These are **monthly** payroll deductions withheld on a **pre-tax basis**

Select One Option	Delta		Select One Option	VSP Vision	
Employee Only	☐ $12.58	☐ I decline dental insurance	Employee Only	☐ $5.02	☐ I decline vision insurance
Employee + Spouse	☐ $36.92		Employee + Spouse	☐ $8.92	
Employee + Child(ren)	☐ $46.22		Employee + Child(ren)	☐ $9.10	
Employee + Family	☐ $68.28		Employee + Family	☐ $14.68	

E. LONG TERM DISABILITY – Hartford

This is a Company-Paid Benefit

Salary: ____________________________ If hourly, how many hours/wk? ________ LTD Amount(ER fill): ________

F. DEPENDENT COVERAGE

Coverage	ADD: Medical	ADD: Dental	ADD: Vision	ADD: Life	Gender	Last Name, First Name (please print clearly)	Social Security #	Date of Birth
Spouse	☐	☐	☐	☐	M / F			
Child	☐	☐	☐	☐	M / F			
Child	☐	☐	☐	☐	M / F			
Child	☐	☐	☐	☐	M / F			
Child	☐	☐	☐	☐	M / F			
Child	☐	☐	☐	☐	M / F			
Child	☐	☐	☐	☐	M / F			

H. SHORT TERM DISABILITY – Hartford

This is an Employee Paid Benefit

☐ I am electing coverage
☐ I am waiving coverage
Age on April 1st
Under 35 $8.78
35 – 49 $6.77
50 – 59 $8.46
60+ $10.40

Short Term Disability (STD) pays you in the event of a loss of income due to disability either by sickness or injury, after a 14-day elimination period, up to a maximum period of 13 weeks. (4 weeks maximum with a pre-existing condition, such as pregnancy). The STD program provides a maximum benefit of 60% of your weekly income, rounded to the next lower $100, up to $1,000 per week. **The rates on the left are per $100/per week. (ie if you are under 35 years old and you receive $500 per week your rate will be $43.90 per month.**

I. BASIC LIFE INSURANCE

All full time Employees of the Diocese of Pensacola are eligible for $25,000 in Basic Life Insurance where the Employer and Employee share in the cost of the Insurance.

VOLUNTARY LIFE INSURANCE – Hartford Life Insurance Company

Voluntary Life is available to you and your dependents. Employees can elect coverage in **$10,000** increments to lesser of 5x Salary or $500,000 maximum. You may elect coverage for your spouse in $5,000 increments with a $250,000 maximum not to exceed 50% of employee amount. You may elect child life coverage in the amounts of **$1,000, $5,000** or **$10,000** . To have coverage on your Spouse or Children you must elect Voluntary coverage on yourself.
Please refer to the Enrollment Guide for Voluntary Life rates.

Employee	**Employee**	**Spouse**	**Child**
☐ I am electing coverage	☐ I am electing coverage	☐ I am electing coverage	☐ I am electing coverage
☐ I am waiving coverage	☐ I am waiving coverage	☐ I am waiving coverage	☐ I am waiving coverage
	Amount Elected:	Amount Elected:	Amount Elected

Please complete Evidence of Insurability form for all Voluntary Life Elections.

J. LIFE INSURANCE BENEFICIARY INFORMATION

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. When naming your beneficiary (ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, “Not Related” next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel.
If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example “33% to Mary Jones, Mother, and 67% to Edith Jones, Wife.”

Full Name	Address	Social Security Number	Relationship	Date of Birth	%

K. EMPLOYEE SIGNATURE / SUPERVISOR SIGNATURE

I understand that by signing and submitting this form, I authorize Diocese of Pensacola-Tallahassee to adjust my pay accordingly through payroll deductions. I understand that my Medical, Dental, and Vision deductions will be made on a pre-tax basis. My elections will remain in effect until next open enrollment and they cannot be changed during the plan year, unless I experience a qualifying event. I may change a benefit election upon the occurrence of a valid qualifying event only if the event affects my own, my spouse’s or my dependent’s coverage eligibility. Examples of a qualifying event may include the birth, adoption, or legal custody of a child, marriage, divorce, or if a covered dependent is no longer eligible for coverage. If I experience a qualifying event, I must report the qualifying event to Human Resources within 30 days of the event.

I understand that this form must be signed and dated prior to my plan effective date to be eligible to participate in this plan year. Prior to the first day of each plan year (April 1). I will be offered the opportunity to change my benefit elections for the following year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit coverage then in effect for the new plan year and I understand that my payroll deductions will change to the rates for the new plan year.

Employee Signature: ________________________________ Supervisor Signature: ______________________________________

Today’s Date: ___________________________ Effective Date of Insurance: ____________________________