ARCHDIOCESE OF NEW YORK

# EMPLOYEE BENEFITS ENROLLMENT & CHANGE FORM

Employees must return completed forms to their Local Benefits Administrator **within 30 calendar days** for:
new enrollments, qualified life events, or for any demographic change(s). **Failure to do so may result in loss of coverage.**

## ADMINISTRATOR USE ONLY

| ❑ New Enrollment | ❑ Change to Existing Benefits | Employee Annual Salary $_____ | Effective or Change Date(mm/dd/yyyy): _____ |
|---|---|---|---|

## Employee Information

| Please select the appropriate plan(s) for enrollment or changes: | ❑ Health Enrollment | ❑ Dental Enrollment | ❑ Vision Enrollment |
|---|---|---|---|

| Please select the reason(s) for completing the Benefits Enrollment & Change Form: | ❑ New Hire | ❑ Waive Coverage | ❑ Address Change | ❑ Name Change | ❑ Update Salary | ❑ Hours Change | ❑ Medicare Eligible |
|---|---|---|---|---|---|---|---|
| | ❑ Dependent Enrollment(s) | ❑ Cancel Dependent(s) | ❑ Qualified Life Event (list reason): _____ | | | | |

**Last Name:** _____ **First Name:** _____ **MI:** ____ **Gender:** ❑ **Male** ❑ **Female**

**Date of Birth:** _____ **SSN:** _____ **Marital Status:** ❑ **Single** ❑ **Married - Marriage Date**_____ ❑ **Divorced** ❑ **Widowed**

**Address:** _____ **Apt. #:** _____ **City:** _____ **State:** ____ **Zip:** _____

**Home Phone:** _____ **Cell Phone:** _____ **Email Address:** _____

**Dependent Information:**
For each plan, please list the name(s) of eligible dependent(s) to be covered (spouse/children). A child is considered a dependent until the end of the month in which they reach age 26. A Continuation of Coverage Enrollment Form will automatically be mailed to dependent children prior to reaching age 26 (Continuation of Coverage is not available for Dental or Vision).

**Disabled Child:**
To apply for extension of coverage for a disabled child before the child reaches the limiting age of 26, please contact the benefit office.

**Documentation:**
Proof of each dependent's eligibility must be attached to this form. For your spouse, attach a copy of your marriage certificate; for each child, attach a copy of his/her birth certificate, adoption, or legal guardianship documents.

**Employee Last Name:** _____ **Employee First Name:** _____ **MI:** _____

## Health Plan Coverage: Medical (United Healthcare) & Prescription (CVS/CAREMARK)

| | | | | | | |
|---|---|---|---|---|---|---|
| **Health Plan Election (select one):** | ❑ Single | ❑ Two Person | ❑ Family | ❑ Clergy | ❑ Religious | ❑ Waive Health Coverage |
| **Payroll Contribution Election (select one):** *I have elected to withhold from my paycheck on the following basis* | | | | | ❑ Pre-Tax Basis | ❑ Post-Tax Basis |

| Add | Remove | Employee/Dependent Full Name | Sex | Date of Birth | Relationship to Employee | Social Security # | Disabled? |
|---|---|---|---|---|---|---|---|
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |

## CIGNA Dental Preferred Provider Organization (PPO): 2023 Dental Plan Election & Annual Costs:

| | | | | | | |
|---|---|---|---|---|---|---|
| **Dental Plan Election (select one)** | ❑ Single Coverage Cost - $474.88 | ❑ Two Person Coverage Cost - $995.87 | ❑ Family Coverage Cost - $1,610.93 | ❑ Clergy | ❑ Religious | ❑ Waive Dental Coverage |

| Add | Remove | Employee/Dependent Full Name | Sex | Date of Birth | Relationship to Employee | Social Security # | Disabled? |
|---|---|---|---|---|---|---|---|
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |

## DAVIS Vision Plan

## 2023 Vision Plan Election & Annual Costs:

| Vision Plan Election (select one) | ❑ Single Coverage Cost - $60.00 | ❑ Two Person Coverage Cost - $120.00 | ❑ Family Coverage Cost - $180.00 | ❑ Clergy | ❑ Religious | ❑ Waive Vision Coverage |
|---|---|---|---|---|---|---|

| Add | Remove | Employee/Dependent Full Name | Sex | Date of Birth | Relationship to Employee | Social Security # | Disabled? |
|---|---|---|---|---|---|---|---|
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |
| ❑ | ❑ | | ❑M ❑F | | | | ❑Yes ❑No |

**EMPLOYEE SIGNATURE:**

My signature below affirms eligibility for coverage, and authorization to deduct any and all contributions from my paycheck. All information provided is complete and true to the best of my knowledge. Any person who knowingly and with intent to defraud, submits an application for health, dental, or vision benefits or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent act, which subjects such person to civil penalties. If retired or otherwise not actively at work, I agree to pay the applicable premium required or portion thereof within 30 calendar days of the premium due date.

**Employee Signature (Required):** _____ **Date:** _____

**Last Name:** _____ **First Name:** _____ **MI:** _____

**ADMINISTRATOR USE ONLY - To be completed by Local Benefits Administrator/Human Resources Coordinator**

**Employee Status:** ❑ **Full-Time** ❑ **Part-Time Benefits Eligible** **Regular Weekly Work Hours:** _____ **Employee Annual Salary: $**_____

**Date of Hire:** _____ **Occupation:** _____ **Covered by Collective Bargaining Agreement?** ❑ **Yes** ❑ **No**

**Institution Name:** _____ **Institution/Dept #:** _____/_____ **Division Code:** _____

**Address:** _____ **City:** _____ **State:** ____ **Zip Code:** _____

**Employer Contact Phone Number:** _____ **Employer Contact Email Address:** _____

**Employer Signature (Required):** _____ **Print Name:** _____ **Date:** _____

**Administrators:** **Please send completed form to Employee Benefit Connections at ebc@archny.org. For any questions or further assistance, please call (646) 794-3060.**

**For Clergy:** **For Clergy, please send completed forms to priestpersonnel@archny.org. For any questions or further assistance with Clergy, please call (646) 794-2934.**