ARCHDIOCESE OF NEW YORK

2020 MEDICAL BENEFIT PLAN OPEN ENROLLMENT FORM

If you are not making any changes to your current Group Medical Coverage, you do not need to complete this form. Your completed form must be returned to your Local Administrator no later than **December 10, 2019,** if you wish to make changes, or if you wish to waive your group health coverage effective **January 1, 2020.**

Please check applicable box: ☐ Employee Enrollment ☐ Dependent Enrollment ☐ Waive Coverage

List the name(s) of your dependent(s) who you want covered under the Archdiocese Health Plan. Eligible dependents are your spouse and dependent children to the end of the month in which each child reaches age 26 and not Medicare eligible.

To apply for an extension of coverage for a disabled child, you must apply before the child reaches the limiting age. Obtain, complete and return the **Statement of Eligibility Beyond Limiting Age in the Plan Due a Disability Form.**

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.

Add	Remove	Dependent's First Name (Include last name only if different from yours)	Sex (M/F)	Date of Birth (MM/DD/YY)	Relationship to Employee	Social Security Number	Disabled ? (Yes/No)

Select from the following coverage options for the Plan Year for your **Medical** coverage.
Refer to the rate sheet in your Enrollment Kit for 2020 contributions amounts:

☐ Single ☐ Two Person ☐ Family

Institution Number:_____ **Claim Division Code:**_____

Employee Name:_____

Home Address:_____

City:_____ **ST:**_____ **Zip:**_____

Payroll Contribution Election:
I elect to have my contributions for Medical coverage subtracted from my pay on the following basis: ☐ Pre-tax ☐ Post-tax

Print Name: _____ **SSN#:** _____

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

To be completed by Benefits Administrator (if you are a Regional Employee, (you MUST return the form to your HR Coordinator)

Status: ☐ Full-time employee ☐ Part-time employee ☐ Retired Regular Weekly Work Hours _____
Occupation_____ Annual Salary $_____
Covered by Collective Bargaining Agreement? ☐ Yes ☐ No

Employer's Signature (Required) _____ Date _____
Employer Print Name (Required) _____ Inst. #:_____

Administrators/GRSS HR Coordinators: Email or Fax a copy of this form together with any supporting documentation to Employee Benefit Connections , fax number: 212-644-0690 or email to EBC@archny.org

10/28/19