

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

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change to Existing Benefits	Employee Annual Salary \$ _____	Effective or Change Date(mm/dd/yyyy): _____
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Employee Information

Please select the appropriate plan(s) for enrollment or changes:		<input type="checkbox"/> Health Enrollment		<input type="checkbox"/> Dental Enrollment		<input type="checkbox"/> Vision Enrollment	
Please select the reason(s) for completing the Benefits Enrollment & Change Form:	<input type="checkbox"/> New Hire	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Update Salary	<input type="checkbox"/> Hours Change	<input type="checkbox"/> Medicare Eligible
	<input type="checkbox"/> Dependent Enrollment(s)		<input type="checkbox"/> Cancel Dependent(s)		<input type="checkbox"/> Qualified Life Event (list reason): _____		
Last Name: _____ First Name: _____ MI: ____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female							
Date of Birth: _____ SSN: _____ Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married - Marriage Date _____ <input type="checkbox"/> Divorced <input type="checkbox"/> 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 (Surest) & Prescription (CVS/CAREMARK)							
Health Plan Election (select one):		<input type="checkbox"/> Single	<input type="checkbox"/> Two Person	<input type="checkbox"/> Family	<input type="checkbox"/> Clergy	<input type="checkbox"/> Religious	<input type="checkbox"/> Waive Health Coverage		
Payroll Contribution Election (select one): <i>I have elected to withhold from my paycheck on the following basis</i>						<input type="checkbox"/> Pre-Tax Basis	<input type="checkbox"/> Post-Tax Basis		
Add	Remove	Employee/Dependent Full Name	Sex	Date of Birth	Relationship to Employee	Social Security #	Disabled?		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		

CIGNA Dental Preferred Provider Organization (PPO): 2026 Dental Plan Election & Annual Costs:									
Dental Plan Election (select one)		<input type="checkbox"/> Single Coverage Cost - \$503.37	<input type="checkbox"/> Two Person Coverage Cost - \$1,055.62	<input type="checkbox"/> Family Coverage Cost - \$1,707.49	<input type="checkbox"/> Clergy	<input type="checkbox"/> Religious	<input type="checkbox"/> Waive Dental Coverage		
Add	Remove	Employee/Dependent Full Name	Sex	Date of Birth	Relationship to Employee	Social Security #	Disabled?		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		

DAVIS Vision Plan

2026 Vision Plan Election & Annual Costs:



Vision Plan Election (select one)		<input type="checkbox"/> Single Coverage Cost - \$60.00	<input type="checkbox"/> Two Person Coverage Cost - \$120.00	<input type="checkbox"/> Family Coverage Cost - \$180.00	<input type="checkbox"/> Clergy	<input type="checkbox"/> Religious	<input type="checkbox"/> Waive Vision Coverage	
Add	Remove	Employee/Dependent Full Name		Sex	Date of Birth	Relationship to Employee	Social Security #	Disabled?
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> 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.