Diocese of Columbus

Change Form for
Employee Benefits

Qualifying Events

- ► Birth, adoption or guardianship of a child;
- ► Court Administrative Order;
- ► Marriage;
- ► Divorce;
- ► Loss of Coverage (includes loss of employment by spouse); or
- ► Death

Please note that no exceptions can be made for you to change your enrollment benefit selections unless one of the above life-changing events occurs and you make the change no later than 31 days after the date of the qualifying event.

CATHOLIC DIOCESE OF COLUMBUS
CHANGE ENROLLMENT FORM

Name: ____ Location: ____________________________
(Last Name, First Name, Middle Initial

Home Address, City & Zip: ____

Job Title: ____ Effective Date: ________________________

E-Mail Address: ____

Reason for Change: ____

Please indicate below the insurance coverage you wish to select:

Medical Benefits (Base): _____ Employee _____Emp. + 1 _____ Family _____ I decline
Medical Benefits (Enhanced): _____ Employee _____ Emp. + 1 _____ Family _____ I decline
Dental Benefits (Base): _____ Employee _____ Emp. + 1 _____ Family _____ I decline
Dental Benefits (Enhanced): _____ Employee _____ Emp. + 1 _____ Family _____ I decline
Vision Benefits (Base): _____ Employee _____ Emp. + 1 _____ Family _____ I decline
Vision Benefits (Enhanced): _____ Employee _____ Emp. + 1 _____ Family _____ I decline

Please indicate below the dependent(s) you are adding or deleting. If adding a dependent(s) for Health, please **include verifying documentation** (recent tax return – black-out confidential information, birth certificate for children, marriage certificate for recent marriages, etc.). Please note that dependents will **not** be covered without their social security number.

Name	Social Security #	Gender	Date of Birth	Add	Delete

Life Insurance: Term Life & AD&D Buy-Up ______________________________
Employee Paid **(Amount)**

List Beneficiaries:

Name	Relationship	SSN	DOB	Benefit %	
					Primary
					Primary
					Contingent
					Contingent

Spouse Life Insurance: Spouse Life & AD&D Buy-Up: ____________________
(Must be in $5,000 increments) **(Amount)**
Limit 50% of employee election - **Employee Paid–Rate Based on Age of employee**

List Beneficiaries:

Name	Relationship	SSN	DOB	Benefit %	
____________	____________	____________	____________	____________	Primary
____________	____________	____________	____________	____________	Primary
____________	____________	____________	____________	____________	Contingent
____________	____________	____________	____________	____________	Contingent

Dependent Child Life: Dependent Life & AD&D Buy-up __________________
($25,000 - age over 6 months **(Amount)**
$1,000 – age under 6 months) - **Employee Paid ($5.00)**

List Beneficiaries:

Name	Relationship	SSN	DOB	Benefit %	
____________	____________	____________	____________	____________	Primary
____________	____________	____________	____________	____________	Primary
____________	____________	____________	____________	____________	Contingent
____________	____________	____________	____________	____________	Contingent

Flexible Spending Account (FSA): _____________ Amount per pay
Maximum annual amount is $2,500; $10 per pay minimum

Dependent Care Account (DCA): ______________ Amount per pay
Maximum annual amount is $5,000; $10 per pay minimum

By my signature below, I hereby authorize the Diocese of Columbus to deduct from my pay the established employee premium for the benefits changes I indicated above.

I understand these rates will remain in effect throughout the calendar year unless I experience a life-changing event or my employment is terminated with the Diocese of Columbus.

______________________________________ ___________________________________

Employee Signature **Date**

DIOCESE OF COLUMBUS

Eligibility: All regular employees who are **expected** to work 30 or more hours per week are eligible for group benefits, i.e., health, dental, vision, group life, short term disability, long term disability, FSA and DCA available through the Diocesan group plan. Part-time, temporary or seasonal employees are not eligible for group benefits. All employees must be a paid employee receiving a W-2 form annually. **The effective date of coverage for new hires is the first day of the month following his or her hire date.**

An eligible employee who chooses single + one or family coverage, which includes his/her spouse, and their spouse has access to group health coverage or spouse is receiving any cash/credit from employer to purchase health coverage elsewhere, the employee must pay the additional spousal premium listed below to receive coverage for the spouse.

Note: The premiums below include additional government fees due to the Affordable Healthcare Act. The imposition of these fees may impact the historical employer/employee cost sharing.

Aetna, P. O. Box 981106, El Paso, TX 79998-1106, (800) 238-6716, www.aetna.com

Health Enhanced Plan (Self - Funded Plan)	Monthly Premium	**Employee Share**	Employer Share
Single	$ 963.00	$ 193.00	$ 770.00
Single + One	2,078.00	416.00	1,662.00
Single + One + Spousal Premium Program	2,078.00	1,308.00	770.00
Family	2,378.00	476.00	1,902.00
Family + Spouse Premium Program	2,378.00	1,379.00	999.00
Health Base Plan (Self - Funded Plan)			
Single	$ 696.00	$ 104.00	$ 592.00
Single + One	1,502.00	225.00	1,277.00
Single + One + Spousal Premium Program	1,502.00	910.00	592.00
Family	1,718.00	258.00	1,460.00
Family + Spouse Premium Program	1,718.00	945.00	773.00

Aetna, P. O. Box 14094, Lexington, KY 40512-4094, 1-877-238-6200, www.aetna.com

Dental Enhanced Plan (Self - Funded Plan)	Monthly Premium	**Employee Share**	Employer Share
Single	$ 49.00	**$ 18.00**	$ 31.00
Single + One	97.00	**35.00**	62.00
Family	149.00	**54.00**	95.00
Dental Base Plan (Self Funded Plan)			
Single	28.00	**4.00**	24.00
Single + One	54.00	**8.00**	46.00
Family	95.00	**12.00**	83.00

Vision Service Plan (VSP), www.vsp.com, 1-800-877-7195; for more Information, contact the Insurance Office at (614) 224-1221

Vision Service Plan (VSP) – Enhanced Plan	Monthly Premium	**Employee Share**	Employer Share
Single	$ 10.00	**$ 10.00**	None
Single + One	20.00	**20.00**	None
Family	31.00	**31.00**	None
Vision Service Plan (VSP) – Base Plan			
Single	$ 6.00	**$ 6.00**	None
Single + One	10.00	**10.00**	None
Family	15.00	**15.00**	None

The Standard - for more Information, contact the Insurance Office at (614) 224-1221

Life Insurance	Monthly Premium	**Employee Share**	Employer Share
$50,000 Term Life	$ 10.00	**$ -0-**	$ 10.00
Voluntary Life Buy-Up (Optional)	Based on Age Band	**Payroll deduction**	$ -0-

Lincoln Financial Group, Cincinnati, Ohio, www.LFG.com; for more Information, contact the Insurance Office at (614) 224-1221

STD - Short Term Disability	Monthly Premium	**Employee Share**	Employer Share
Plan	$ 19.00	**$ -0-**	$ 19.00

Lincoln Financial Group, Cincinnati, Ohio, www.LFG.com; for more Information, contact the Insurance Office at (614) 224-1221

LTD - Long Term Disability	Monthly Premium	**Employee Share**	Employer Share
Plan 1 (Base)	$ 5.00	**$ -0-**	$ 5.00
Plan 2 (Optional Buy-Up)	21.00	**21.00**	$ -0-

CATHOLIC DIOCESE OF COLUMBUS
SPOUSAL EMPLOYMENT STATEMENT

This is to verify that my spouse is **NOT** eligible for, **OR** enrolled in, any other group health coverage and/or is **NOT** receiving any cash/credit from an employer to purchase health coverage elsewhere.

Please check the applicable category description, and **ATTACH** any documentation listed as required - (Notary witness is **NOT** required for these categories):

❑ Group health coverage is not offered to my spouse - **MUST** provide verification letter from spouse's employer

❑ My Spouse is self-employed - **MUST** provide verification of self-employment: i.e., tax I.D. #, business card, letterhead, invoice, etc.

❑ Spouse is also an employee of the Diocese

❑ My Spouse is enrolled at his/her place of employment as primary - A copy of the spouse's group health insurance card (both sides) **MUST** be attached for a spouse to be enrolled as secondary coverage.

____

Spouse's Employer Name

____

Spouse's Employer Address **Phone**

The following categories **require Notary Witness**:

❑ Spouse is not employed ❑ Spouse is retired

NOTE: The employee is responsible for notifying the individual responsible for payroll at his/her location for any changes that occur during the year in regards to his/her spouse's employment or benefit status before any change will be made to this Program.

I certify and confirm that this is a true statement by my signature below.

____

Employee Name (please print) **Employee Signature** **Date**

Witness by Notary,

STATE OF ____________________________ COUNTY OF ______________________________________

BEFORE ME, the undersigned, a Notary Public, personally appeared ________________________________

who executed the above Spousal Employment Statement as a free and voluntary act.

IN WITNESS WHEREOF, I have signed my name and affixed my official notarial seal

this day of________________, 20___. ____

(SEAL) **Notary Public** **My Commission Expires**

PLEASE FAX or RETURN FORM to the:

Catholic Diocese of Columbus
Attention: Insurance Office
197 East Gay Street
Columbus, OH 43215-3766
*Fax: 614-241-*2573

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