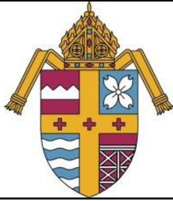


Diocese of Knoxville
Human Resources
Group Health Insurance Form

Please print clearly and complete ALL Information ❒ Full-time ❒ Part-time

Parish or Institution____

Name____ SSN:________/________/________

Address____ Date of Birth____/________/________

City______________________ State____________ Zip Code______________ Sex: ❒ Male ❒ Female

Phone Number__________________ E-Mail ________________________________

Work Information Title ____________________ Location ________________ Date of Hire __________

Other Insurance Information *(please include Medicare information)*

Do you or any members of your family have other insurance? ❒ Yes ❒ No

If yes, please provide the following information:

Persons Covered:________________________________ Effective Date of Coverage: ______________

Carrier:________________________________ Policy #: ______________

Plan Elections

Effective Date: ____________________ **MEDICAL INSURANCE**

Plan of Benefits with United Health Care ❒ **Elect** ❒ **Change** ❒ **Remove**

❒ UHC Standard PPO: ❒ Employee ❒ Employee + one ❒ Family

❒ UHC HDHP: ❒ Employee ❒ Employee + one ❒ Family

❒ No Medical Coverage Desired ► *Why ?* ❒ Coverage elsewhere Reason ______________________

Effective Date: ____________________ **DENTAL INSURANCE**

Plan of Benefits with United Health Care ❒ **Elect** ❒ **Change** ❒ **Remove**

UHC DENTAL: ❒ Employee ❒ Employee + one ❒ Family

❒ No Dental Coverage Desired

Effective Date: ____________________ **VISION**

Plan of Benefits with VSP ❒ **Elect** ❒ **Change** ❒ **Remove**

VSP Vision : ❒ Employee ❒ Employee + one ❒ Family **your option**

❒ No Vision Coverage Desired

Health Savings Account (HSA): ***HSA IS ONLY AVAILABLE FOR QUALIFIED HDHP PLAN*** Elect: ❒ Waive: ❒ Change: ❒

$________________ x________________ = $____________________ Per Plan Year Effective Date: ____________

Dollar Amount **# of Pay Periods** **Total Amount**

Maximum $3,600 annual Employee Only (Employer will contribute $600 of this maximum)
Maximum $7,200 annual Family (Employer will contribute $1,200 of this maximum)
If electing HSA, you are required to complete the attached Authorized Agent Agreement.

PLEASE COMPLETE EMPLOYEE AND DEPENDENT INFORMATION					
*Only your Legal Souse and natural, adopted or stepchildren who meet the dependent requirements are eligible for coverage.					
Employee	Social Security #	Last Name First Name M.I.	Sex	Date of Birth	Coverage Desired
			❒ Male ❒ Female	___/___/___	❒ Medical ❒ Dental ❒ Vision
Spouse*	Social Security #	Last Name First Name M.I.	Sex	Date of Birth	Coverage Desired
			❒ Male ❒ Female	___/___/___	❒ Medical ❒ Dental ❒ Vision
Child*	Social Security #	Last Name First Name M.I.	Sex	Date of Birth	Coverage Desired
			❒ Male ❒ Female	___/___/___	❒ Medical ❒ Dental ❒ Vision ❒ Handicapped
Child*	Social Security #	Last Name First Name M.I.	Sex	Date of Birth	Coverage Desired
			❒ Male ❒ Female	___/___/___	❒ Medical ❒ Dental ❒ Vision ❒ Handicapped
Child*	Social Security #	Last Name First Name M.I.	Sex	Date of Birth	Coverage Desired
			❒ Male ❒ Female	___/___/___	❒ Medical ❒ Dental ❒ Vision ❒ Handicapped
Child*	Social Security #	Last Name First Name M.I.	Sex	Date of Birth	Coverage Desired
			❒ Male ❒ Female	___/___/___	❒ Medical ❒ Dental ❒ Vision ❒ Handicapped
❒ **Additional dependents listed on separate page**					

YOUR AUTHORIZATION:

The Diocese of Knoxville provides you the opportunity to pay your contributions for medical, dental, vision and HSA with pre-tax dollars through the Section 125 Premium Only Plan. By enrolling in the Diocese of Knoxville benefit plan you are acknowledging that you understand that your deductions will be pre-tax. You can save approximately 25% of each dollar spent on these expenses when you participate in this plan or more depending on your Estimated Tax Rate. Should you choose not to have your deductions taken pre-tax, please contact your HR Department.

I acknowledge that I have received and read the enrollment materials for the Diocese of Knoxville Employee Benefit Program and that I have read the information on this form.

I acknowledge that the above information represents my enrollment choice(s). **I understand that by signing this form, I am authorizing pre-tax contributions to be withheld from my pay for the coverages selected. I further understand that my pre-tax elections cannot be changed or canceled until a future benefits enrollment period or an employment or family status change occurs.** By signing this form, I represent to the best of my knowledge and belief, all statements and answers made on this form are true, complete and correct. I have not knowingly withheld any fact of circumstance that would, if disclosed, affect my application unfavorably. I understand that any misrepresentation, deception, or false statement made on this Enrollment Form may result in my or my dependents not being enrolled in the insurance plan(s), and if not discovered by the Company until after my becoming enrolled, is grounds for, and may result in, my or my dependents immediate termination from the plan(s).

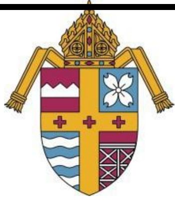
I understand that the redirection of my cash compensation under this agreement shall be in addition to any redirection under other agreements or benefit plans. Under Federal Law, any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year, and that my social security benefits may be slightly affected as a result of my election. This agreement is subject to the terms of the employer's cafeteria plan as amended from time to time in effect, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation redirection agreement relating to such plan(s).

I acknowledge that I have read the attached Health Saving Information Sheet attached to this form.

Employee Signature:____ Date: ______________________

HR Approval:____ Date: ______________________

Please E-mail completed form to: Human Resources – mlentz@dioknox.org
Or mail to: Human Resources, Diocese of Knoxville 805 S. Northshore Dr. Knoxville, TN 37919



Diocese of Knoxville
Appointment of Employer as Authorized Agent to Open HSA

Social Security #	Last Name	First Name	Middle Initial	Date of Birth
______--______--_______				___/___/___

Street Address (NOT P.O. Box)	City	State	Zip Code

Phone Number	Country of Citizenship	Residency Status (US Citizen or Permanent Resident or Non-Permanent/Non-Resident Alien)

Email address	Additional Card for Authorized Signer	Name of Additional Authorized Signer
	❐ Yes ❐ No	

Appointment and Certification

By signing below, I appoint **THE DIOCESE OF KNOXVILLE** ("Employer") as my agent for the purpose of opening and administering/maintaining an Optum Bank, Inc. ("Bank") Health Savings Account ("HSA") on my behalf and authorize Employer to send and receive information to and from the Bank on my behalf (including account number) in order to accomplish this purpose. I authorize the Bank to make any inquiries that it considers appropriate to determine if it should open and maintain my HSA, and I acknowledge that I have received the Bank's USA PATRIOT Act Notice provided below:.

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

I certify that I am eligible to contribute to an HSA under Internal Revenue Code Section 223. I authorize and direct the Bank to issue a Debit MasterCard® to me. I certify that I have received the Bank's statement of the hardware and software requirements for access to and retention of electronic records and that I have the ability to access the Bank's website where electronic statements and other documentation are stored. I instruct the Bank, unless otherwise notified and instructed by me, to provide the Custodial and Deposit Agreement and all other HSA notices, disclosures and information related to and governing my HSA to me online at www.optumbank.com. I understand that monthly account statements and other documentation and notices will be delivered or made available electronically. If I want HSA statements mailed to my home, I must notify the Bank directly.

I agree that Employer will remain my agent unless and until Employer and the Bank receive notice that the appointment of Employer as my agent has been terminated, that I am no longer employed by Employer, or that I am no longer an HSA eligible individual; or I receive a notice from the Bank that my application for an HSA has been declined.

__________________________________ ________________________
Employee Signature **Date**

Please E-mail completed form to: Human Resources – mlentz@dioknox.org
Or mail to: Human Resources, Diocese of Knoxville 805 S. Northshore Dr. Knoxville, TN 37919