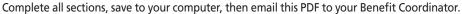
Benefits Program Enrollment Form Complete all sections, save to your computer, then email this PDF to your Benefit Coordinator.





Employee Information COMPLETE: Check One: New Enrollment Change Benefits (mark changes only)	For Benefit Coordinator Use: To ensure that elections are processed correctly, you MUST fill in the Location (Pay) Code and Group or Policy Number for each benefit elected. Medical Group #: Effective Date: Dental Group #: Salary:								
□ Waive Medical□ Change: Qualified Life Event	Voluntary Life: Loc. Code Voluntary AD&D: Loc. Code Policy# OK822					(required for life insurance only) 711 Employer Signature			
Name:									
Home Address:							-	Single \(\square\) Marrie	ed
								Divorced ☐ Wido	
Parish/Agency Where You Work:									
Date of Birth:	Date	of Hire:				Sex:		Male ☐ Fema	ıle
Home Phone:	Work	Phone:				Email:			
Dependent/Coverage Informa	tion								
(Complete for all eligible dependents of the right to verify eligibility of all depe	enrolled for c	overage. The Arch	ndioc	ese reserves		You must e HMO, POS	or Dent	rovider number fo al DHMO coverag	е
Name		(mth/day/year)	Sex	Social Security N	o. Me	edical Provider #	Existing Patient	Dental Provider #	Existing Patient
(Employee)									
(Spouse)									
(Child)									
(Child)									+
(Child)			L						
(Child)									
Medical Coverage (Please choor	se option and	type of coverage. I	or PC	OS or HMO, enter	PCP's nai	me/address).	I		
Plan Selection ☐ Personal Choice PPO ☐ Personal Choice HDHP ☐ Keystone Point-of-Service (POS) ☐ Keystone Health Plan East HMO ☐ No coverage (By making this election signing this form, I certify that I lectoverage elsewhere.) 2. Dental Coverage (Please choose	tion and nave	Type of Coverage Employee On Employee & C Employee & C Employee & S Full Family (Note: Abortion and	ly Child Childro pous	En PC PC en e —— untary sterilization	nter PCP I EP Name: EP Addre	nformation for standard phone #	‡ : an offered	d by the Archdiocese. Office (PDO) or Aet)
Primary Care Dentist (PCD): Plan Selection Concordia Plus Dental DHMO Plar Concordia Flex Dental PPO Plan Aetna Dental DMO Plan Aetna Dental PPO Plan No coverage	☐ Employee Only or Aet ☐ Employee & Child Name: ☐ Employee & Children Addres			Aetna Dl me: dress and	nformation for Concordia DHMO Dental Office (PDO) na DMO Primary Care Dentist (PCD) s and Phone #:				
3. Voluntary Life Insurance (Providence) I choose the following Voluntary Life a	ided by the Lif	e Insurance Compa	ny of	North America (a l my children:	CIGNA :	subsidiary) Polic	y #VTL4	38)	
Employee coverage amount \$		Enter a	an an	nount from \$10	,000 to	\$500,000 (in	10,000	multiples)	
Spouse coverage amount \$									
Child(ren) coverage amount \$									
(Additional medical information will be	required to app	prove certain amou	nts of	coverage or if you	ı enroll af	ter you are first	eligible (or increase your cove	erage.)
4. Voluntary Accidental Death & I choose the following Voluntary AD& Coverage Amount \$your coverage cannot be more than 10 ti	D coverage: Enter an amo mes your pay.	Type of Coverage	e 0 to \$	□ None \$300,000 (in \$10	☐ Y 0,000 mt	ou Only ultiples); if you l	You ar	nd Family* rage of \$250,000 or	
5. Voluntary Life and/or Volunt	=		_						
Primary Beneficiary									
Primary Beneficiary								ntage %	
Secondary Beneficiary									
Secondary Beneficiary		Rel	ation	ship			Percer	ntage %	
Employee's Agreement (This secting the best of my knowledge, the about any required contributions from the year only plan. Further, I understand that this e are yes, I have read and understand the this eread are the this eread and understand the this eread are the thin erea	ove information my regular if I experience lection will re	on is true and con pay. If required on e a change in fam main in effect un	nplete contri ilv sta	e. I request the obutions are made atus as defined by	coverage le on a b ov the Ar	elected above efore-tax basis chdiocese of P	hiladelp	ect the Archdioce: rstand that my ele hia Premium Conv	se to ction ersion
Do you agree to be legally bound by t	' '	3	Yes	. Lagree □ N	No, I disa	aree			
If completing by hand Print Name:	p.oyec	g. co.mem		Signatur		J. ==			

Instructions For Beneficiary Designation

- 1. You may name anyone as beneficiary of your Voluntary Life and/or Voluntary AD&D insurance. If you wish to name more than one primary beneficiary, enter their names without numbering or using the words "and/or." If you wish to name a secondary beneficiary in the event your primary beneficiary should predecease you, please complete the Secondary Beneficiary section. (You should know that in most cases a guardian must be appointed by court action before payment of a benefit can be made to a minor.)
- 2. If you make an error in entering names, relationship of beneficiary(ies) to you, or percentage of benefits, secure a new form, but do not make any erasures or changes. Show a beneficiary's own full name—for example, "Mary Jane Smith," not "Mrs. John E. Smith."
- 3. If a trustee is to be named, a special form may be required. See your Benefit Coordinator
- 4. List the percentage of the benefit to be paid to each primary and each secondary beneficiary.
- 5. Sign the enrollment form in ink, using the signature you normally use on official documents, and enter the date of signing.
- 6. Be sure to consider whether you should complete a new beneficiary designation form in the event of your marriage or divorce; failure to do so may result in payment of benefits to an unintended recipient.
- 7. If any beneficiary dies before you, a new beneficiary designation form should be filed, unless you have named more than one beneficiary and are satisfied with the manner in which the old designation will operate, as indicated on the form.
- 8. If more than one primary beneficiary is designated, then in the event a primary beneficiary predeceases you, death benefits will be divided among the surviving primary beneficiaries in the ratio established by your chosen percentages.
- 9. If more than one secondary beneficiary is designated, then in the event a secondary beneficiary predeceases you, death benefits will be divided among the surviving secondary beneficiaries in the ratio established by your chosen percentages.
- 10. If no beneficiary is named, your legal spouse will receive benefits if you were married at the time of your death; otherwise, benefits will be paid in this order: to your children, parents, siblings, and lastly to your estate.