Archdiocese of Philadelphia Parishes And Agencies

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)
- ☐ Waive Medical
- ☐ Change: Qualified Life Event

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:** _____ (required for life insurance only)

Voluntary Life: Loc. Code_____

Voluntary AD&D : Loc. Code_____ Policy# OK822711 **Employer Signature**_____

Name: _____ **Social Security #:**_____

Home Address: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

_____

Parish/Agency Where You Work:_____

Date of Birth: _____ **Date of Hire:** _____ **Sex:** ☐ Male ☐ Female

Home Phone: _____ **Work Phone:** _____ **Email:** _____

Dependent/Coverage Information

(Complete for all eligible dependents enrolled for coverage. The Archdiocese reserves the right to verify eligibility of all dependents.)

Name	Birth Date (mth/day/year)	Sex	Social Security No.	You must enter a provider number for HMO, POS or Dental DHMO coverage: Medical Provider #	Existing Patient	Dental Provider #	Existing Patient
(Employee)							
(Spouse)							
(Child)							
(Child)							
(Child)							
(Child)							

1. Medical Coverage

(Please choose option and type of coverage. For POS or HMO, enter PCP's name/address).

Plan Selection

- ☐ Personal Choice PPO
- ☐ Personal Choice HDHP
- ☐ Keystone Point-of-Service (POS)
- ☐ Keystone Health Plan East HMO
- ☐ No coverage **(By making this election and signing this form, I certify that I have coverage elsewhere.)**

Type of Coverage

- ☐ Employee Only
- ☐ Employee & Child
- ☐ Employee & Children
- ☐ Employee & Spouse
- ☐ Full Family

Enter PCP Information for Keystone POS or Keystone HMO

PCP Name: _____

PCP Address and Phone # :

_____

_____

(Note: Abortion and voluntary sterilization are not covered by any plan offered by the Archdiocese.)

2. Dental Coverage

(Please choose option and type of coverage. Enter Name/Address for Concordia DHMO Primary Dental Office (PDO) or Aetna DMO Primary Care Dentist (PCD):

Plan Selection

- ☐ Concordia Plus Dental **DHMO** Plan
- ☐ Concordia Flex Dental **PPO** Plan
- ☐ Aetna Dental **DMO** Plan
- ☐ Aetna Dental **PPO** Plan
- ☐ No coverage

Type of Coverage

- ☐ Employee Only
- ☐ Employee & Child
- ☐ Employee & Children
- ☐ Employee & Spouse
- ☐ Full Family

Enter Information for Concordia DHMO Dental Office (PDO) or Aetna DMO Primary Care Dentist (PCD)

Name: _____

Address and Phone # :

_____

3. Voluntary Life Insurance

Policy #VTL438 insured by New York Life Group Benefit Solutions. Note: Active employees regularly scheduled at least 20 hours a week are eligible for a $15,000 life insurance benefit. I choose the following Voluntary Life amounts for myself, my spouse, and my children:

Employee coverage amount $_____Enter an amount from $10,000 to $500,000 (in 10,000 multiples)

Spouse coverage amount $_____Enter an amount from $10,000 to $200,000 (in 10,000 multiples)

Child(ren) coverage amount $_____Enter $5,000 or $10,000.

(Additional medical information will be required to approve certain amounts of coverage or if you enroll after you are first eligible or increase your coverage.)

4. Voluntary Accidental Death & Dismemberment Insurance (AD&D)

Policy #OK822711 insured by New York Life Group Benefit Solutions.

I choose the following Voluntary AD&D coverage: **Type of Coverage** ☐ None ☐ You Only ☐ You and Family*

Coverage Amount $_____ Enter an amount from $10,000 to $300,000 (in $10,000 multiples); **if you buy coverage of $250,000 or more, your coverage cannot be more than 10 times your pay.**

**The plan pays a percentage of your coverage amount if your spouse or child dies or suffers certain serious injuries.*

5. Voluntary Life and/or Voluntary AD&D Insurance Beneficiary

(See page 2 for instructions.)

Primary Beneficiary _____ Relationship _____ Percentage %_____

Primary Beneficiary _____ Relationship _____ Percentage %_____

Secondary Beneficiary_____ Relationship _____ Percentage %_____

Secondary Beneficiary_____ Relationship _____ Percentage %_____

Employee's Agreement

(This section must be completed before emailing to your Benefit Coordinator.)

To the best of my knowledge, the above information is true and complete. I request the coverage elected above and direct the Archdiocese to deduct any required contributions from my regular pay. If required contributions are made on a before-tax basis, I understand that my election may be changed during the year only if I experience a change in family status as defined by the Archdiocese of Philadelphia Premium Conversion Plan. Further, I understand that this election will remain in effect until July 1 and thereafter, unless changed by me.

☐ Yes, I have read and understand the Employee's Agreement.

Do you agree to be legally bound by the Employee's Agreement? ☐ Yes, I agree ☐ No, I disagree

If completing by hand **Print Name:** _____ **Signature:** _____

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.