ARCHDIOCESE OF LOUISVILLE
BENEFIT ENROLLMENT FORM - 2019 PLAN YEAR

PARISH, SCHOOL, GROUP: _____ **Group #:** _____

EMPLOYEE INFORMATION (please print clearly)

Name: _____ _____ _____ **SSN:** _____
Last First Middle

Cell Phone: _____ **Home Phone:** _____

Home Address: _____
Street City State Zip

Date of Birth: _____ **Email Address:** _____

Original Hire Date: _____ **Job Title:** _____

Local Hire Date: _____ **Gender:** _____ **Marital Status:** _____

Hours Worked (per week): _____ **Weeks Worked (per year):** _____ **Annual Salary: $** _____

Employees must work 30 or more hours per week to be eligible for benefits.

BENEFITS PROVIDED BY THE ARCHDIOCESE OF LOUISVILLE

☐ **TERM LIFE INSURANCE**

Beneficiary's Name: _____ _____ _____ **Relationship:** _____
Last First Middle

☐ **LONG TERM DISABILITY COVERAGE**

BENEFITS PAID FROM EMPLOYEE PRE-TAX INCOME

MEDICAL COVERAGE (Check one) **Coverage First**

☐ **Individual** $610.40 ☐ **Employee +1** $1,220.82 ☐ **Family** $1,831.22

☐ **If I have elected to cover my spouse under my medical coverage, I hereby advise that my spouse is not eligible for coverage under his/her employer. By signing this form below, I certify this information to be true and correct to the best of my knowledge and understand that any misstatement constitutes fraud.**

☐ **I do not elect medical coverage.**

DENTAL COVERAGE (Check one)

	Preventive Plus	Humana PPO	Traditional Preferred
☐ EE	$14.82	$26.84	$35.98
☐ EE+SP	$32.32	$47.44	$71.48
☐ EE+Child(ren)	$36.26	$52.64	$72.88
☐ Family	$56.42	$90.20	$118.24

☐ **I do not elect dental coverage.**

VISION COVERAGE (Check one)

Humana Vision 130

☐ **EE** $7.26 ☐ **EE + 1** $15.08 ☐ **Family** $20.60

☐ **I do not elect vision coverage.**

FLEXIBLE SPENDING ACCOUNTS - Indicate amount to be contributed in whole dollars.

Any monies remaining in spending accounts at plan year end will be forfeited in accordance with IRS regulations.

☐ **Health Care Account $** _____ **per month (minimum $75 per month; maximum $2,650 per year)**

☐ **Dependent Care Acct $** _____ **per month (minimum $75 per month; maximum-see plan booklet)**

☐ **I do not elect to participate in the Flexible Spending Accounts.**

BENEFITS PAID FROM EMPLOYEE TAXABLE INCOME

☐ **SHORT-TERM DISABILITY (see plan booklet for rates)**

☐ **I do not elect Short-term Disability**

I have received the 2019 Summary Plan Description and understand that I cannot change my benefit elections, except for specific reasons permitted by the IRS, until the next open enrollment.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

BOOKKEEPER/ADMINISTRATOR: _____ **DATE:** _____

NOTE: Original For Parish Files; Pink To Employee; Yellow To Pastoral Center.