ARCHDIOCESE OF LOUISVILLE BENEFIT ENROLLMENT FORM - 2020 PLAN YEAR

PARISH, SCHOOL, GROUP: _____ Group #: _____

EMPLOYEE INFORMATION (please	print clearly)					
Name:				SSN:_		
Last		First	Middl	e		
Cell Phone:			Home Phone:			
Home Address:						_
Street				State	Zip	
Date of Birth:						
Original Hire Date:	Job Title:					
Local Hire Date:				Marital S	tatus:	
Hours Worked (per week):	Weeks Worke	d (per year):		Annual Salary	: \$	
Employees must work 30 or more hours per week to be eligible for benefits.						
BENEFITS PROVIDED BY THE ARC	CHDIOCESE OF LOUIS	SVILLE				
TERM LIFE INSURANCE Beneficiary's Name:				Pa	elationship:	
Deficition y S. Name.	Last	First	Middle		nationship	
ONG TERM DISABILITY COV	/ERAGE					
BENEFITS PAID FROM EMPLOYEE						
MEDICAL COVERAGE (Check one)		Coverage F	irst PPO			
☐ Individual	\$637.44	Employee +1	\$1,274.92	☐ Family	\$1,912.36	
 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)			Humana I	PPO T	raditional Preferred	
	Preventive Plus	•			EE	
		\$14.82 \$32.32	□ EE+SP	\$26.84 L \$47.44 [」 EE+SP	\$35.98
	EE+SP	\$36.26	EE+Child(ren)		- -	\$71.48
]	EE+Child(ren)	\$56.42	Family	\$90.20	_ EE+Child(ren)	\$72.88
I do not elect dental coverage.	Family				Family	\$118.24
VISION COVERAGE (Check one) Humana Vision 130						
	☐ EE \$7.26	_ E	EE + 1 \$15.08	F	amily	\$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 \$2,700 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 TA	XABLE INCOME (see p	olan booklet for r	ates)			
SHORT-TERM DISABILITY I do not elect Short-Term Disability.						
GROUP TERM SUPPLEMENTAL	LIFE I do not el	lect Supplementa	al Life coverage.			
I have received the 2020 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:				DA	TE:	
BOOKKEEPER/ADMINISTRATO			<u> </u>	DA	TE:	
NOTE: Original For Parish Files; Pink To Employee; Yellow To Pastoral Center.						