ROMAN CATHOLIC DIOCESE OF BURLINGTON

Health and Welfare Benefit Plan Enrollment Form

This form must be completed within 30 days of the date of initial eligibility or Qualifying Life Event or the employee will forfeit the right to enroll in certain benefits until the next open enrollment or the employee experiences a Qualifying Life Event as defined by the IRS. Please send your completed form to Mary Foster at mfoster@vermontcatholic.org or Human Resources, 55 Joy Drive, South Burlington, VT 05403.

Section I: Employee Information

Last Name	First Name	Middle Initial	SSN	Date of Birth

Street Address/P.O. Box	City	State and Zip

Phone Number	Email

Gender	Relationship Status: Single, Married, Divorced

Employer:_____

_____ (*Unless otherwise noted, benefits begin the first day of the month after date of hire or the first day of the month after the employee enters a benefits eligible employment status.)*
Date Benefits Begin

Section II: Employee's Spouse/Dependent Information

Please list ALL persons who qualify as your dependents.

Dependent Name (Last, First, MI)	Gender	Relationship*	Date of Birth	SSN

**Relationship: Spouse, Child, Stepchild, Foster Child*
Child Status: If child is age 26+ coverage is available only if child is disabled.

I attest that the person(s) listed above are my dependents as defined by the IRS and I certify that I can provide proof of dependent status (valid marriage certificate, birth/adoption certificate, etc.) if requested to do so. I further agree to notify Human Resources within 30 days of a change in family status that may affect benefits eligibility.

Signature	Date

Section III: Medical, Dental and Vision Coverage

A: Elect to Participate

Medical Coverage: ☐ Single ☐ Employee and Spouse ☐ Employee and Children ☐ Employee and Family

Medical Plan Type: ☐ Platinum ☐ Gold

List the Names of Dependents for Medical Coverage: _____

Dental Coverage: ☐ Single ☐ Two Person ☐ Family

Dental Plan Type: ☐ High ☐ Low

List the Names of Dependents for Dental Coverage: _____

Vision Coverage: ☐ Single ☐ Two Person ☐ Family

List the Names of Dependents for Vision Coverage: _____

I hereby authorize my employer to withhold all employee portions of the medical, dental, and/or vision premiums (as outlined on the benefit rate worksheet) from my pay. I understand that contributions are withheld on a pre-tax basis. I understand that if I do not make an election to participate, I will not be able to enroll/change my selections until next annual open enrollment or I experience a Qualifying Life Event as defined by the IRS.

_____ _____

Employee Signature Date

B: Decline Participation

☐ I DO NOT wish to participate in Medical _____ Dental _____ Vision _____. I understand that if I do not make an election to participate within 30 days of my date of hire, I will not be able to enroll/change my selections until next annual open enrollment or I experience a Qualifying Life Event as defined by the IRS.

_____ _____

Employee Signature Date

Section IV: Life and Accidental Death and Dismemberment Insurance

Some employers provide Life coverage of $25,000 to the employee and an additional Accidental Death and Dismemberment (AD&D) benefit of $25,000. If your employer offers Life/AD&D, you will be automatically enrolled in this 100% employer-paid Life/AD&D coverage. Please review the Benefits Rate Sheet to confirm if your employer participates in this plan.

If you are eligible for Life/AD&D, please complete the Equitable/AXA Beneficiary Designation Form which is included in your Benefits Packet. You must return the completed form to Human Resources to complete the process.

_____ _____

Employee Signature Date

Section V: Beneficiary Designation – Life Insurance Plan

I designate the person(s) named below to receive payment, in the event of my death, under the Life/AD&D benefit program (if eligible).

Name (Last, First, MI)	SSN	Relation to You	Percentage (must equal 100%)

Signature and Certification

_____ _____

Employee Signature Date

Section V: Disability Insurance

Some employers provide Short-Term (STD) and Long-Term Disability (LTD) insurance coverage to the employee. If your employer offers STD and LTD, you will be automatically enrolled in the 100% employer-paid disability benefits. Please review the Benefits Rate Sheet to confirm if your employer participates in the plan.

Section VI: Signature

I received a benefits packet, or I have opted to access the benefits information electronically (via email or at www.vermontcatholic.org). I have also received current rate information for the benefits programs mentioned on the current benefits rate sheet. I agree to: 1) abide by the terms outlined in the materials provided; 2) have the appropriate employee contributions withheld from my pay; 3) confirm that the correct deductions are withheld from my pay and agree to deduction corrections if necessary; and 4) notify Human Resources within 30 days of a Qualifying Life Event (for example: marriage, divorce, birth of a child, child custody change, dependent child turns age 26, etc.) that may affect benefit eligibility.

I understand that failure to promptly notify Human Resources of a Qualifying Life Event may result in loss of benefit coverage, forfeiture of COBRA rights (after 60 days), personal financial liability for claims paid on behalf of an ineligible family member, inability to change pre-tax deduction level to reflect loss of coverage, inability to add dependents. I understand that I will not be able to change my benefit elections until the next annual open enrollment, unless I have an eligible Qualifying Life Event as defined by the IRS.

_____ _____

Employee Signature Date