Diocese of Columbus

Change Form for Employee Benefits

Qualifying Events

- Birth, adoption or guardianship of a child;
- Court Administrative Order;
- Marriage;
- Divorce;
- Loss of Coverage (includes loss of employment by spouse); or
- Death

Please note that no exceptions can be made for you to change your enrollment benefit selections unless one of the above life-changing events occurs and you make the change no later than 31 days after the date of the qualifying event.

CATHOLIC DIOCESE OF COLUMBUS
CHANGE ENROLLMENT FORM

Name: _____ Location: _____
(Last Name, First Name, Middle Initial

Home Address, City & Zip: _____

Job Title: _____ Effective Date: _____

E-Mail Address: _____

Reason for Change: _____

Please indicate below the insurance coverage you wish to select:

Medical Benefits (Base): ____ Employee ____ Emp. + 1 ____ Family ____ I decline
Medical Benefits (Enhanced): ____ Employee ____ Emp. + 1 ____ Family ____ I decline
Dental Benefits (Base): ____ Employee ____ Emp. + 1 ____ Family ____ I decline
Dental Benefits (Enhanced): ____ Employee ____ Emp. + 1 ____ Family ____ I decline
Vision Benefits (Base): ____ Employee ____ Emp. + 1 ____ Family ____ I decline
Vision Benefits (Enhanced): ____ Employee ____ Emp. + 1 ____ Family ____ I decline

Please indicate below the dependent(s) you are adding or deleting. If adding a dependent(s) for Health, please **include verifying documentation** (recent tax return – black-out confidential information, birth certificate for children, marriage certificate for recent marriages, etc.). Please note that dependents will **not** be covered without their social security number.

Name	Social Security #	Gender	Date of Birth	Add	Delete

Life Insurance: Term Life & AD&D Buy-Up _____
Employee Paid **(Amount)**

List Beneficiaries:

Name	Relationship	SSN	DOB	Benefit %	
					Primary
					Primary
					Contingent
					Contingent

Spouse Life Insurance: Spouse Life & AD&D Buy-Up: _____
(Must be in $5,000 increments) **(Amount)**
Limit 50% of employee election - **Employee Paid–Rate Based on Age of employee**

List Beneficiaries:

Name	Relationship	SSN	DOB	Benefit %	
					Primary
					Primary
					Contingent
					Contingent

Dependent Child Life: Dependent Life & AD&D Buy-up _____
($25,000 - age over 6 months **(Amount)**
$1,000 – age under 6 months) - **Employee Paid ($5.00)**

List Beneficiaries:

Name	Relationship	SSN	DOB	Benefit %	
					Primary
					Primary
					Contingent
					Contingent

Flexible Spending Account (FSA): _____ Amount per pay
Maximum annual amount is $2,500; $10 per pay minimum

Dependent Care Account (DCA): _____ Amount per pay
Maximum annual amount is $5,000; $10 per pay minimum

By my signature below, I hereby authorize the Diocese of Columbus to deduct from my pay the established employee premium for the benefits changes I indicated above.

I understand these rates will remain in effect throughout the calendar year unless I experience a life-changing event or my employment is terminated with the Diocese of Columbus.

_____ _____
Employee Signature **Date**

DIOCESE OF COLUMBUS

BENEFIT RATES EFFECTIVE - January 1, 2018 through December 31, 2018

Eligibility: All regular employees who are **expected** to work 30 or more hours per week are eligible for group benefits, i.e., health, dental, vision, group life, short term disability, long term disability, FSA and DCA available through the Diocesan group plan. Part-time, temporary or seasonal employees are not eligible for group benefits. All employees must be a paid employee receiving a W-2 form annually. **The effective date of coverage for new hires is the first day of the month following his or her start date.**

An eligible employee who chooses single + one or family coverage, which includes his/her spouse, and their spouse has access to group health coverage or spouse is receiving any cash/credit from employer to purchase health coverage elsewhere, the employee must pay the additional spousal premium listed below to receive coverage for the spouse.

Note: The premiums below include additional government fees due to the Affordable Healthcare Act. The imposition of these fees may impact the historical employer/employee cost sharing.

United HealthCare of Ohio, P.O. Box 30555 Salt Lake City, UT 84130-0555, 1-866-633-2446 www.myuhc.com

Health Enhanced Plan (Self - Funded Plan)	Monthly Premium	**Employee Share**	Employer Share
Single	$ 865.00	**$ 173.00**	$ 692.00
Single + One	1,867.00	**373.00**	1,494.00
Single + One + Spousal Premium Program	1,867.00	**1,175.00**	692.00
Family	2,137.00	**427.00**	1,710.00
Family + Spouse Premium Program	2,137.00	**1,239.00**	898.00
Health Base Plan (Self - Funded Plan)			
Single	$ 625.00	**$ 94.00**	$ 531.00
Single + One	1,349.00	**202.00**	1,147.00
Single + One + Spousal Premium Program	1,349.00	**818.00**	531.00
Family	1,543.00	**231.00**	1,312.00
Family + Spouse Premium Program	1,543.00	**849.00**	694.00

United HealthCare of Ohio, P.O. Box 30555 Salt Lake City, UT 84130-0555, 1-866-633-2446 www.myuhc.com

Dental Enhanced Plan (Self - Funded Plan)	Monthly Premium	**Employee Share**	Employer Share
Single	$ 46.50	**$ 17.50**	$ 29.00
Single + One	92.00	**33.00**	59.00
Family	142.00	**52.00**	90.00
Dental Base Plan (Self Funded Plan)			
Single	27.00	**3.50**	23.50
Single + One	51.00	**6.00**	45.00
Family	90.00	**10.00**	80.00

Vision Service Plan (VSP), www.vsp.com, 1-800-877-7195; For more Information, contact the Insurance Office at (614) 224-1221

Vision Service Plan (VSP) – Enhanced Plan	Monthly Premium	**Employee Share**	Employer Share
Single	$ 10.00	**$ 10.00**	None
Single + One	20.00	**20.00**	None
Family	31.00	**31.00**	None
Vision Service Plan (VSP) – Base Plan			
Single	$ 6.00	**$ 6.00**	None
Single + One	10.00	**10.00**	None
Family	15.00	**15.00**	None

Lincoln Financial Group, Cincinnati, Ohio, www.LFG.com; For more Information, contact the Insurance Office at (614) 224-1221

Life Insurance	Monthly Premium	**Employee Share**	Employer Share
$50,000 Term Life	$ 11.50	**$ -0-**	$ 11.50
Voluntary Life Buy-Up (Optional)	Based on Age Band	**Payroll deduction**	$ -0-

Lincoln Financial Group, Cincinnati, Ohio, www.LFG.com; For more Information, contact the Insurance Office at (614) 224-1221

STD - Short Term Disability	Monthly Premium	**Employee Share**	Employer Share
Plan	$ 18.00	**$ -0-**	$ 18.00

Lincoln Financial Group, Cincinnati, Ohio, www.LFG.com; For more Information, contact the Insurance Office at (614) 224-1221

LTD - Long Term Disability	Monthly Premium	**Employee Share**	Employer Share
Plan 1 (Base)	$ 4.00	**$ -0-**	$ 4.00
Plan 2 (Optional Buy-Up)	14.00	**14.00**	$ -0-

CATHOLIC DIOCESE OF COLUMBUS
SPOUSAL EMPLOYMENT STATEMENT

This is to verify that my spouse is not eligible for or enrolled in any **group** health coverage **and** my spouse is not receiving any cash/credit from employer to purchase health coverage elsewhere (please check one):

- ❑ Group health coverage is not offered to my spouse (must provide verification letter from spouse's employer)
- ❑ Spouse is self-employed (Must provide some type of verification of self-employment, i.e., letterhead, invoice, business card, etc.)
- ❑ Spouse is not employed
- ❑ Spouse is also employed by the Diocese
- ❑ Spouse is retired
- ❑ Spouse is enrolled at his/her place of employment as primary (a copy of the spouse's group health insurance card must be attached to this form and returned to the Insurance Office at the address below to be added as secondary coverage)

Name of Spouse's Employer: _____

Address: _____ **Phone:** _____

NOTE:
The employee is responsible for notifying the appropriate individual of the Diocese for any changes that occur during the year in regards to his/her spouse's employment or benefit status before any changes will be made to this Program. If providing verification from the spouse's employer, self-employment or a spouse's health card, the Notary witness is **not** required.

I certify and confirm that this is a true statement by my signature below.

_____ _____
Employee Signature Date

Witness by Notary,
STATE OF _____ COUNTY OF _____

BEFORE ME, the undersigned, a Notary Public, personally appeared

_____ who executed the above Spousal Employment Statement as a free and voluntary act.

IN WITNESS WHEREOF, I have signed my name and affixed my official notarial seal this

_____ day of _____, 20_____.

(SEAL)

Notary Public_____

My Commission Expires: _____

PLEASE RETURN FORM TO THE INSURANCE OFFICE

Catholic Diocese of Columbus
198 East Broad Street
Columbus, OH 43215-3766
ATTN: Insurance Office
Fax: 614-241-2573