DIOCESE of COLUMBUS

FULL TIME NEW HIRE ENROLLMENT FORM

Name: _____ Location: _____

(Last Name, First Name, Middle Initial)

Home Address, City & Zip: _____

SS#: _____ Birth Date: _____ Marital Status: _____ Home Phone #: _____

Job Title: _____ First FT Working Day: _____

Effective Date: _____ **Salary:** _____

Scheduled Hours per Week: _____ Pay Frequency: _____ Status: Full-Time

E-Mail Address: _____

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

(Emp. + 1 = Emp. + Child(ren) or Emp. + Spouse)

If electing Family coverage for Health, Dental or Vision, please list your dependents below and **include verifying documentation** (recent tax return—black-out confidential information, birth certificate for children, marriage certificate for recent marriage, etc.). Please note that dependents will **not** be covered without their social security number.

Name	Social Security #	Gender	Date of Birth
_____	_____	M _____	_____
_____	_____	M _____	_____
_____	_____	M _____	_____
_____	_____	M _____	_____
_____	_____	M _____	_____

Life Insurance: $50,000 _____
Employer Paid

Term Life & AD&D Buy-Up _____
Up to 7x Salary or $350,000, **(Amount)**
(whichever is less without evidence of insurability -
Employee Paid-Rate Based on Age of employee

List Beneficiaries:

Name	Relationship	SSN	DOB	Benefit %	
_____	_____	_____	_____	0.00%	Primary
_____	_____	_____	_____	0.00%	Primary
_____	_____	_____	_____	0.00%	Primary
_____	_____	_____	_____	0.00%	Contingent
_____	_____	_____	_____	0.00%	Contingent
_____	_____	_____	_____	0.00%	Contingent

Spouse Life Insurance: Spouse Life & AD&D Buy-Up: _____
($5,000 up to $100,000 without evidence of insurability) **(Amount)**
Limit 50% of employee election - **Employee Paid–Rate Based on Age of employee**

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

Short Term Disability: Plan pays 65% of income after 7 consecutive days of disability.
Employer Paid _____

Long Term Disability:

_____Base Plan	_____ Buy-Up Plan
Base Plan pays 40% of Income after 90 days	Buy-Up pays 65% of Income after 90 days
Employer Paid	**(Cost to you = $21.00/month)**

Flexible Spending Account (FSA): _____ Annual Amount
Maximum annual amount is $3,200 (payroll deduction is required over 24 pays) - $120 annual minimum

Dependent Care Account (DCA): _____Annual Amount
Maximum annual amount is $5,000 (payroll deduction is required over 24 pays) - $120 annual minimum

By my signature below, I hereby authorize the Diocese of Columbus to deduct from my pay the established employee premium for the benefits I selected 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**