

2022 Medical & Dental Benefits Annual Enrollment Form New or Change

Diocese of California
Group # 0086 Medical Billing Unit: 805
1055 Taylor St. San Francisco, CA 94108

☐ Annual Enrollment

Coverage Effective Date: **Jan 1, 2022***

*Ins. effective date is the 1st of the month following date of hire.
Retroactive new or changes can be made to the 1st of the month within 60 days

PRIMARY MEMBER'S PERSONAL INFORMATION (please respond to all items)

Legal Name (last) _____ (first) _____

Social Security #: _____ Birth Date (mm/dd/yy): _____ Gender (circle one): **F / M / X**

Home Address: _____

City, State, Zip: _____

Mobile Ph: (____) _____ Personal Email: _____

Marital/Partner Status (circle one): Single Married State Registered Domestic Partnership

Benefit Elections (check the box & circle the level of coverage of your selection)

Medical Plan:	Monthly Premiums:	Single	Dual	Family
<input type="checkbox"/> Kaiser EPO 80		\$924.55	\$1,664.60	\$2,589.15
<input type="checkbox"/> Anthem BCBS BlueCard PPO 80		\$984.00	\$1,771.20	\$2,755.20
<input type="checkbox"/> Anthem BCBS BlueCard PPO 90		\$1,083.43	\$1,950.58	\$3,034.00
<input type="checkbox"/> Kaiser EPO High		\$1,144.93	\$2,061.28	\$3,206.20
<input type="checkbox"/> I decline medical coverage at this time (consult with employer who may offer a benefit waiver allowance)				

Dental Plan:			
<input type="checkbox"/> Cigna Dental/Ortho	\$ 78.93	\$142.48	\$221.40
<input type="checkbox"/> I decline dental coverage at this time (consult with employer who may offer a benefit waiver allowance)			

Dependent Information (list those to be added or removed from medical & dental coverage)

Children, up to age 30, may be enrolled in our plans*. If you wish to enroll one or more dependents please list them below, use additional page if necessary.

	Names	Date of Birth	Social Security #	Gender	Circle Add (+) or Delete (-)
Partner/Spouse:	_____	_____	_____	M / F / X	+ / - Med + / - Dental
Child(ren):	_____	_____	_____	M / F / X	+ / - Med + / - Dental
	_____	_____	_____	M / F / X	+ / - Med + / - Dental
	_____	_____	_____	M / F / X	+ / - Med + / - Dental

*Depending upon employing entity's cost share policy, the employee may be responsible for premiums for children ages 25+ or 19+ if not a full-time student. Please contact DioCal Benefits Administrator to clarify employer's cost share policy, email: sarahc@diocal.org or ph: 415-869-7805

Authorizing Information

Employee Status = (circle one)

Estimated average hours scheduled per week

20 - <30 hrs/wk

Premiums billed to employer but medical or dental may be the responsibility of employee. To set up PR deductions for any/all health ins premiums contact DioCal PR office for the form

30 or more hrs/wk

At minimum, Kaiser EPO 80 is paid in full by employer. Check with employer on cost-share policy for higher cost plans. Premiums can be processed at pre-tax PR deductions

Employee's Signature & Date: _____

Employer Authorized (name/sign, contact # or email): _____