## 2024 Diocese of Central Gulf Coast Benefits Enrollment Form

**Member Information**

| | |
|---|---|
| **Name** | **Position Title** |

| | |
|---|---|
| **Home Address** | **City, State, Zip** |

| | | | |
|---|---|---|---|
| **Email** | **Telephone Number** ( ) - | **S or M ? Date of Marriage: _____** | **If Married, complete spouse info. Pg 2.** |

| | | | |
|---|---|---|---|
| **DOB** | **Social Security Number** | **Employer/Church, City, State** | **Hours/Week** |

| | | |
|---|---|---|
| **Hire Date** | □ **Female** □ **Male** **Gender** | **Effective Date of Policies (1st of Month)** |

## Employee Assistance Program (EAP) - ONLY

□ Employee Assistance Program **ONLY** (if not on a Church Medical Trust Plan)

## Medical

**SELECT ONE √ (REQUIRED or WAIVED* see box below)**

| **Plan Name** | | **Single** | **Emp+1** | **Family** |
|---|---|---|---|---|
| □ | Anthem BCBS CDHP 40 | □ | □ | □ |
| □ | Anthem BCBS CDHP 20 | □ | □ | □ |
| □ | Anthem BCBS CDHP 15 | □ | □ | □ |
| □ | Anthem BCBS BlueCard PPO 70 | □ | □ | □ |
| □ | Anthem BCBS BlueCard PPO 80 | □ | □ | □ |
| □ | Anthem BCBS BlueCard PPO 90 | □ | □ | □ |
| □ | **MSP** Anthem BCBS BlueCard PPO 80 | □ | □ | |
| □ | **MSP** Anthem BCBS BlueCard PPO 90 | □ | □ | |

***Wavier of Medical Benefits (if applicable)**

I have been offered health benefits coverage through the Denominational Health Plan from my employer and

□ I decline enrollment at this time because I am purchasing a health plan through either the federal or state health insurance Marketplace and can establish that I am eligible to receive a premium tax credit. Or,

□ I decline enrollment at this time because I am covered on my spouse's insurance or other approved insurance.

_____ _____

Signature of Employee Date

**Spouse/Dependent Information** You may obtain coverage for your children who are age 30 or younger. If you wish to enroll dependents please complete the following for EACH enrolled dependent below (attach additional sheets, if necessary):

| | | | | |
|---|---|---|---|---|
| | □ **F** □ **M** | | | □ **Spouse** □ **Partner** □ **Child** □ **Disabled** |
| **Name** | **Gender** | **DOB** | **SSN** | **RELATION** |
| | □ **F** □ **M** | | | □ **Child** □ **Disabled** |
| **Name** | **Gender** | **DOB** | **SSN** | **RELATION** |
| | □ **F** □ **M** | | | □ **Child** □ **Disabled** |
| **Name** | **Gender** | **DOB** | **SSN** | **RELATION** |

## Dental

**SELECT ONE √ (OPTIONAL)**

| **Plan Name** | **Single** | **Emp+1** | **Family** |
|---|---|---|---|
| □ Delta Basic | □ | □ | □ |
| □ Delta Comprehensive | □ | □ | □ |
| □ Delta Premium & Ortho | □ | □ | □ |

## Life Insurance and Disability

**Group Life Enrollment**
REQUIRED (churches) $40K cvg

**LTD Enrollment? (Lay Only - OPTIONAL)**
□Yes □No □ Employee Paid

**STD Enrollment? (Lay Only - OPTIONAL)**
□Yes □No □ Employee Paid

| $ | $ | □ **Clergy** □ **Lay** | **Rectory?** □ Yes □ No |
|---|---|---|---|
| **Annual Cash Salary** | **Annual Cash Housing (Clergy*)** | | |

*For clergy - as reported to the Church Pension Fund

**Sign and return to Kim Weinstein (kim@diocgc.org or fax 850-434-8577) at the Diocesan Office.**

Employee Signature and Date

Employer Signature and Date

Diocesan Administrator Signature and Date

**Notes:** Enrollment in benefit plans and Life insurance must be made **within 30 days of hire date**. Short and/or Long Term Disability – First Time Offering Only: Effective dates of coverage are January 1st or July 1st only. Enrollment forms must be received at CPG between October 15 and November 15 for a January 1 effective date and between April 15 and May 15 for a July 1 effective date.