

Employee Enrollment & Change Form 2022

Please submit this form by mail to Anilin Collado, 840 Echo Park Avenue, Los Angeles, CA 90026

Information About the Employee						
New Employee (Complete section 1	through 8)					
Termination (Complete section 1, 2,	Title First Name	MI Last	t name			
Other Status (Note below)						
Status details (Address change, new d	, Hire/Term Date SSN					
	divorce, etc. (Complete all necessary sections) Salary Change \$					
			Birthdate Effective Date			
Residence		Mailing Address				
Street	Street		Street			
City State	Zip	City	State	Zip		
		Male Ma	arried 🗌 Cler	gy		
Home Phone Em	Home Phone Email			Female Single Lay		
2 Billing Information						
Name of Organization		Phone E	mail	List Bill ID		
Street		City	State	Zip		
3 Disability	Life	Unemployment				
Short-term Disability	Short-term Disability Life + AD&D		participate in th	e 🗌 Yes		
Long-term Disability	_	Diocesan Unemployment Plan?				
		Employee's annual salary				
0						
Active Medical Coverage						
Regular Plans	Medicare Secondary Payer (additional forms required) Tier For employees 65 and older enrolled in Medicare and actively working (Only available to employers with no more than 19 employees) Image: Construct of the model of the mo					
Kaiser EPO High Plan Kaiser EPO 80 Plan						
Kaiser CDHP-20/HSA						
Anthem CDHP – 15/HSA	Anthem BCBS BlueCard MSP PPO 100 Employee + Spouse Structure Anthem BCBS BlueCard MSP PPO 90 Employee + Child (ren					
Anthem CDHP – 20/HSA	Anthem BCBS BlueCard MSP PPO 80					
Anthem CDHP – 40/HSA	Anthem BCBS BlueCard MSP PPO 70					
Anthem BCBS BlueCard PPO 100						
Anthem BCBS BlueCard PPO 90						
Anthem BCBS BlueCard PPO 80						
EAP Only						

•	Enrollment and Change Form for the Diocese of Los Angeles				
5 Active Dental Coverage	Add Coverage	Terminate Coverage			
 Preventive Dental Plan Basic Dental Plan Dental & Ortho Plan Dental coverage declined 		Tier Single Employee + Spouse Employee + Child (ren) Family			
6 Information About Your Dependents Coverage Full Name	Add Coverage	 Terminate Coverage SSN Birthdate (M/D/Y) 	Gender		
Medical Dental Medical	inclutionship .		Male Female		
Dental Medical Dental Dental			Female		

Signature — Employee, Employer and Sponsoring Diocese or Organization

The employee, employer and an officer of the sponsoring diocese or organization must sign this form. By signing, the employer certifies the employee is eligible for all coverages applied for, and, to the best of the employer's knowledge, all information provided is correct.

Employee Signature ** Date Date Name of Sponsoring Diocese or Organization		ite	Employer Signature		Date
		Officer's Signature		Date	
Street	City		State Zip	Phone	Email

*Employee's signature is not required for termination of coverage due to termination of employment. Employee's signature is required for employee's voluntary termination of employee and/ or employee dependent(s) coverage. Please complete section 6 for termination of dependent(s) coverage.

**Include Power of Attorney documentation if applicable.

8

Please return your enrollment within 30 days from your date of hire or date of eligibility.

*Note that your coverage is effective the first of the month following your date of hire or date of eligibility. (If your date of hire or eligibility is the first working day of the month and the first calendar day of the month (e.g., Monday, June 1) coverage begins on the first of that month)

For questions about the form, please contact: Canon Anilin Collado

acollado@ladiocese.org Office number: 213-482-2040, ext. 250 Work cell number: 213-999-3179 Fax number: 213-225-1807