Episcopal Diocese of Los Angeles

Feeding Hungry Hearts

Employee Enrollment & Change Form 2024

Please e-mail this form to: acollado@ladiocese.org

1 Information About the Employee

☐ New Employee (Complete section 1 through 8)
☐ Termination (Complete section 1, 2, 6 & 7 – employer signature)*
☐ Other Status (Note below) _____
Status details (Address change, new dependent, deceased, marriage, divorce, etc. (Complete all necessary sections)
☐ Salary Change $_____
(Complete sections 1, 2 and 7 (employee & employer signature)

Title First Name MI Last name

Hire/Term Date

Effective Date of Coverage

Residence

Street

City State Zip

Home Phone Email

Mailing Address

Street

City State Zip

☐ Male ☐ Female ☐ Clergy ☐ Lay ☐ Married ☐ Single
Date of Marriage: _____

2 Billing Information

Name of Organization

Phone Email List Bill ID

Street

City State Zip

3

Disability

☐ Short-term Disability
☐ Long-term Disability

Life

☐ Life + AD&D

Unemployment

Does the employee participate in the Diocesan Unemployment Plan? ☐ Yes ☐ No

Employee's annual salary _____

4 Active Medical Coverage

Regular Plans

☐ Kaiser EPO High Plan
☐ Kaiser EPO 80 Plan
☐ Kaiser CDHP-20/HSA
☐ Anthem CDHP – 15/HSA
☐ Anthem CDHP – 20/HSA
☐ Anthem CDHP – 40/HSA
☐ Anthem BCBS BlueCard PPO 100
☐ Anthem BCBS BlueCard PPO 90
☐ Anthem BCBS BlueCard PPO 80
☐ Anthem BCBS BlueCard PPO 70
☐ EAP Only
☐ **Medical coverage declined**

Medicare Secondary Payer (additional forms required)

For employees 65 and older enrolled in Medicare and actively working (Only available to employers with no more than 19 employees)

☐ Anthem BCBS BlueCard MSP PPO 100
☐ Anthem BCBS BlueCard MSP PPO 90
☐ Anthem BCBS BlueCard MSP PPO 80
☐ Anthem BCBS BlueCard MSP PPO 70

Tier

☐ Single
☐ Employee + Spouse
☐ Employee + Child (ren)
☐ Family

For Administrators:

Birthdate/s and Social Security Number/s for employee and employee dependent/s must be entered in MY ADMIN PORTAL (MAP) first before sending in this form. Please contact Anilin Collado if you need assistance with entering information in MAP.

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Active Dental Coverage ☐ **Add Coverage** ☐ **Terminate Coverage**

☐ Basic PPO Dental Plan
☐ Comprehensive PPO Dental Plan
☐ Premium Dental PPO Plan

☐ **Dental coverage declined**

Tier
☐ Single
☐ Employee + Spouse
☐ Employee + Child (ren)
☐ Family

6

Information About Your Dependents ☐ Add Coverage ☐ Terminate Coverage

Coverage	Full Name	Relationship	Gender
☐ Medical ☐ Dental			☐ Male ☐ Female
☐ Medical ☐ Dental			☐ Male ☐ Female
☐ Medical ☐ Dental			☐ Male ☐ Female

7

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

Employer Signature Date

Name of Sponsoring Diocese or Organization

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.

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Please return your enrollment within 30 days from your date of hire or date of eligibility.
*Note that employee 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
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Work cell number: 213-999-3179