

Employee Enrollment & Change Form 2025

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

1					
Information About the Employee					
New Employee (Complete section 1 th	rough 8)				
Termination (Complete section 1, 2, 6 & 7 – employer signature)*		Title First Name MI Last name			
Other Status (Note below)	Other Status (Note below) Status details (Address change, new dependent, deceased, marriage,				
Status details (Address change, new de			Hire/Term Date Effective Date of Coverage		
divorce, etc. (Complete all necessary se	ctions)				
Salary Change \$					
(Complete sections 1, 2 and 7 (employe	e & employer signature)				
Residence		Mailing Address			
Street		Street			
City State	Zip	City	State Zip		
		🗌 Male 📃 Clergy	□ Married □ Single		
Home Phone Emai	l	Female Lay	Date of Marriage:		
2 Billing Information					
Name of Organization		Phone Email	List Bill ID		
Street		City	State Zip		
3 Disability	Life	Unemployment			
Short-term Disability	Life + AD&D	Does the employee participate in the Ves			
Long-term Disability		Diocesan Unemployment Plan?			
		Employee's annual salary	V		
3					
Active Medical Coverage					
Regular Plans	Medicare Secondary I	Payer (additional forms rec	<u>uired) Tier</u>		
Kaiser EPO High Plan	For employees 65 and older enrolled in Medicare and actively working				
Kaiser EPO 80 Plan	(Only available to employers with no more than 19 employees) Single				
Kaiser CDHP-20/HSA	Anthem BCBS BlueCard MSP PPO 100				
	Anthem BCBS Blue				
Anthem CDHP – 15/HSA	Anthem BCBS Blue	Card MSP PPO 90	Employee + Child (
		Card MSP PPO 90			
Anthem CDHP – 15/HSA Anthem CDHP – 20/HSA Anthem CDHP – 40/HSA	Anthem BCBS Blue	Card MSP PPO 90 Card MSP PPO 80	Employee + Child (
Anthem CDHP – 15/HSA Anthem CDHP – 20/HSA Anthem CDHP – 40/HSA Anthem BCBS BlueCard PPO 100	Anthem BCBS Blue	Card MSP PPO 90 Card MSP PPO 80	Employee + Child (
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Anthem CDHP – 15/HSA Anthem CDHP – 20/HSA Anthem CDHP – 40/HSA Anthem BCBS BlueCard PPO 100 Anthem BCBS BlueCard PPO 90	Anthem BCBS Blue	Card MSP PPO 90 Card MSP PPO 80	Employee + Child (

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.

Enrollment and Change Form for the Diocese of Lo					
□ Add Coverage	Terminate Coverage				
	<u>Tier</u>				
	Single				
	Employee + Spouse				
	Employee + Child (ren)				
□ Add Coverage	Terminate Coverage				
Relationship	Gender				
	Male				
	E Female				
	Male				
	Female				
	Male				
	E Female				
	□ Add Coverage				

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 Name of Sponsoring Diocese or Organization		Date	Employer Signat	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.

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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 Office number: 213-482-2040, ext. 250 Work cell number: 213-999-3179