



2023 Diocese of Central Gulf Coast Benefits Enrollment Form

Member Information

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Name

Position Title

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Home Address

City, State, Zip

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

Telephone Number

Single/Married/Date

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DOB

Social Security Number

Employer/Church, City, State

Hours/Week

	<input type="checkbox"/> Female <input type="checkbox"/> Male	
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Hire Date

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
<input type="checkbox"/> Anthem BCBS CDHP 40	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anthem BCBS CDHP 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anthem BCBS CDHP 15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anthem BCBS BlueCard PPO 70	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anthem BCBS BlueCard PPO 80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anthem BCBS BlueCard PPO 90	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MSP Anthem BCBS BlueCard PPO 80	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> MSP Anthem BCBS BlueCard PPO 90	<input type="checkbox"/>	<input type="checkbox"/>	

*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):

	<input type="checkbox"/> F <input type="checkbox"/> M			<input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Child <input type="checkbox"/> Disabled
Name	Gender	DOB	SSN	RELATION

	<input type="checkbox"/> F <input type="checkbox"/> M			<input type="checkbox"/> Child <input type="checkbox"/> Disabled
Name	Gender	DOB	SSN	RELATION

	<input type="checkbox"/> F <input type="checkbox"/> M			<input type="checkbox"/> Child <input type="checkbox"/> Disabled
Name	Gender	DOB	SSN	RELATION

Dental

SELECT ONE ✓ (OPTIONAL)

Plan Name	Single	Emp+1	Family
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- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Preventative Dental | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Basic Dental | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Dental & Orthodontia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Life Insurance and Disability

Group Life Enrollment

REQUIRED - \$40,000 cvg

LTD Enrollment? (Lay Only - OPTIONAL)

Yes No Employee Paid

STD Enrollment? (Lay Only - OPTIONAL)

Yes No Employee Paid

\$

<input type="checkbox"/> Clergy <input type="checkbox"/> Lay	Housing Provided? Amount \$ _____
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Annual Salary (Lay or *Clergy)

*For clergy - as reported to the Church Pension Fund (including cash salary and cash housing allowance.)

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

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Employee Signature and Date

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Employer Signature and Date

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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.