Diocese of La Crosse Lay Group Benefits Enrollment & Change Form

SAFS Admin Use Only - Effective Date: _____

Parish/Institution Regis Catholic Schools **City** Eau Claire **#** 702 **Group #** L06588

Employee Info

Last Name | First Name | MI | Birth Date | Social Security Number

Street Address | City | State | Zip | Personal Email | Phone Number

☐ Single ☐ Female

☐ Married ☐ Male

Job Title | First Date of Work / First Date of Eligibility | Hours / Week

Purpose of Form *(Must mark one box)*:

☐ **New Employee** (*Eligible the first of the month, following First Date of Work*)

☐ **Open Enrollment** (*Specific period of time to enroll or make changes*)

☐ **Change**

- ☐ Termination / Resignation / Retirement / Reduction of Hours to _____ Hours / Week Last Day of Work / Eligibility _____
- ☐ Address – provide new address under employee info
- ☐ Name Change New Name _____ Former Name _____
- ☐ Address – provide new address under employee info
- ☐ Dependent(s)
  - ☐ Add ☐ Delete Name _____ Birth Date _____ SS# _____ Relation _____
  - ☐ Add ☐ Delete Name _____ Birth Date _____ SS# _____ Relation _____
- ☐ Qualifying Event _____

State the Qualifying Date and the Qualifying Event - - *(Marriage / Birth / Loss of Coverage / Newly Eligible / Divorce / Etc.)*

Medical / Vision / Dental Election - ***Select elections you are keeping or the elections you are changing to/or select WAIVE***

Medical: ☐ Employee ☐ Family ☐ WAIVE

Plan & Deductible: ☐ Traditional Deductible ☐ High Deductible/HSA

Vision (Included w/Medical if Enrolled): ☐ Employee ☐ Family ☐ WAIVE

Dental: ☐ Employee ☐ Employee & 1 dependent ☐ Family ☐ WAIVE

Other Insurance Coverage

As of your effective date, will there be any other insurance in effect on you or any dependents to be covered? ☐ No ☐ Yes

If Yes, Primary Insured Name _____ Carrier _____ Group/Policy # _____ Effective Date _____

Dependents Covered _____ **Medical** ☐ Employee ☐ Family **Vision** ☐ Employee ☐ Family **Dental** ☐ Employee ☐ Family

Life Insurance Election

Basic Life / AD& D ☐ $30,000 ☐ WAIVE *If not elected at start of employment, evidence of insurability may be requested to enroll in the life insurance plan.*

Primary Beneficiary _____ Relationship _____

Contingent Beneficiary _____ Relationship _____

Community Property State Consent for residents for Wisconsin: If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his/her rights to any community property interest in the benefit.

As the Employee's spouse, I do hereby consent to the beneficiary designation(s) indicated and waive any rights I may have to the proceeds of such life insurance under applicable community property laws.

Spouse Signature _____ **Date** _____

Dependent Information (*List all dependents to be covered under this plan)*:*

	Name (Last, First, Middle Initial)	Sex (M/F)	Birth Date	Social Security Number
Spouse				
Child				
Child				
Child				
Child				

**If additional dependents, please list on next page*

Medical Release / Acceptance / Authorization

I hereby authorize any doctor, hospital, insurance company, employer, or organization to release any information regarding history, treatment, disability, or benefits, but excluding genetic information and family history, for claims to Diocesan Third Party Administrator. A copy of this authorization shall be valid as the original.

I UNDERSTAND THE FOLLOWING: This form will be used for benefit information. The information listed above is correct and true. To verify incorrect information on this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct from my pay my contribution (if any) to the cost of the benefits I have selected. If I am declining enrollment for myself or my dependents because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 31 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 31 days after that event.

I certify the above is true & correct and acknowledge I have been given the opportunity to enroll in the Diocese of La Crosse Group Health, Vision, Dental, & Basic Life Insurance Plans. By not enrolling in certain benefits at this time, I realize I will not be able to enroll or make changes again until the next open enrollment unless I have qualifying event or family status change.

Employee Signature** (Required)* _____ ***Date _____

See Reverse Side for Additional Important Information

St. Ambrose Financial Services, Inc.
P.O. Box 4004
La Crosse, WI 54602-4004
Phone: (608) 791-2669
Fax: (608) 787-8068
https://www.stambrosefinancial.com

Revised 01/2023

OTHER IMPORTANT PLAN INFORMATION

Notice of Enrollment Rights:

I am aware that if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I have other coverage, I may later apply for coverage for me and/or my dependents if eligibility is lost under that other coverage, if the employer stops contributing toward the other coverage or if adding a dependent due to marriage, birth, adoption or placement for adoption. Loss of eligibility may result from one of the following:

1. My spouse loses coverage due to job termination or has a reduction in hours to a status that is ineligible for coverage;
2. My spouse and I divorce;
3. My spouse dies; or
4. The expiration of COBRA for a previous employer.

I am aware if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I do not want coverage for whatever reason, I may later apply for coverage for myself and/or my dependents with a marriage or the birth adoption or placement for adoption of a child.

In addition, you may add a new dependent to your plan as a result of a marriage, birth, adoption, or placement for adoption. Application to add a new dependent must be made within 31 days of the event.

If you qualify for enrollment under any of the above exceptions you must complete and return the signed application to your employer or St. Ambrose Financial Services, Inc. within 31 days of the qualifying event. When adding a dependent to your existing policy, you must complete and return a signed change form to your employer or St. Ambrose Financial Services, Inc. within 30 days of the marriage, birth, adoption, or placement for adoption.

You may also apply for coverage for you and any eligible dependent during the open enrollment period each year.

Eligibility and Effective Date of Coverage:

For newly hired employees, coverage is effective the first of the month following employment in a benefit eligible position.

Age Limits for Dependent Children:

Coverage for eligible children will cease at the end of the month in which the child reaches the age of 26.

If you have any questions about eligibility of particular enrollment changes, contact St. Ambrose Financial Services at 608-791-2669

ADDITIONAL DEPENDENT INFORMATION (*List all dependents to be covered under this plan*):

	Name (Last, First, Middle Initial)	**Sex (M/F)**	**Birth Date**	**Social Security Number**
Child				
Child				
Child				
Child				
Child				
Child				
Child				