



Archdiocese of Galveston-Houston † Benefit Enrollment Form Lay Employees, Religious Sisters and Brothers 2022

This form must be completed and submitted within 31 days of Date of Hire

****Important Dependent Notice Regarding Eligibility below and on page 3****

Employee Information

Lay Employee
 Sister
 Brother

Last Name		First Name		MI	Social Security Number		
Address		City		State	Zip Code		
Home/Cell Phone		Work Phone		Email Address			
Date of Birth	Gender	Marital Status		Job Title	# of Hours	Location & ADP #	
	Female <input type="checkbox"/> Male <input type="checkbox"/>	Single <input type="checkbox"/> Married <input type="checkbox"/>	Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>				
Per Week							

Family Information and Benefits Options

Last Name, First, MI	Social Security	Gender	Relationship	Date of Birth	Medical	Dental	Vision	Supplemental Life
Employee	*****	***	Self	*****				
		F <input type="checkbox"/> M <input type="checkbox"/>	Spouse - Documentations Required					N/A
		F <input type="checkbox"/> M <input type="checkbox"/>	Child - Birth Certificate Required					
		F <input type="checkbox"/> M <input type="checkbox"/>	Child - Birth Certificate Required					
		F <input type="checkbox"/> M <input type="checkbox"/>	Child - Birth Certificate Required					
		F <input type="checkbox"/> M <input type="checkbox"/>	Child - Birth Certificate Required					
		F <input type="checkbox"/> M <input type="checkbox"/>	Child - Birth Certificate Required					
		F <input type="checkbox"/> M <input type="checkbox"/>	Child - Birth Certificate Required					
		F <input type="checkbox"/> M <input type="checkbox"/>	Child - Birth Certificate Required					

If adding dependent(s) to coverage, you must provide supporting documentation that demonstrates eligibility: Marriage Certificate and/or a copy of current Federal Tax Form or other Financial Documents, Birth Certificates, Court Orders or in case of pending adoption, Adoption Agency or Government Placement Papers showing imminent adoption.

Benefits Plans - Medical, Dental, Vision and Supplemental Life

I. Medical Plan		Bi-Weekly Premiums			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	
Standard Tier	<input type="checkbox"/> \$0	<input type="checkbox"/> \$210.46	<input type="checkbox"/> \$161.54	<input type="checkbox"/> \$263.08	
Economy Tier		<input type="checkbox"/> \$179.08	<input type="checkbox"/> \$104.77	<input type="checkbox"/> \$183.23	

I Decline Medical Coverage

****Important Notice Regarding Dependent Eligibility is found on page 3 of this Benefits Enrollment Form. Please read carefully before adding dependent(s).**

II. Dental Plan		Bi-Weekly Premiums			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	
Coverage:	<input type="checkbox"/> \$0	<input type="checkbox"/> \$25.22	<input type="checkbox"/> \$25.22	<input type="checkbox"/> \$42.04	

I Decline Dental Coverage

III. Vision Plan		Bi-Weekly Premiums			
		Employee Only	Employee + One	Employee + Family	
Coverage:		<input type="checkbox"/> \$4.21	<input type="checkbox"/> \$6.08	<input type="checkbox"/> \$11.72	

I Decline Vision Coverage

IV. Supplemental Life Insurance

A. Employee Supplemental Life Insurance Coverage: *Coverage reduced to 67% at age 65, and 50% at age 70.*

- \$25,000 \$75,000
 \$50,000 \$100,000

Bi-Weekly Premiums are listed on next page

B. Child Supplemental Life Insurance Coverage: *Coverage ends at age 25 and must not be married.*

- \$10,000

Bi-Weekly Premiums are listed on next page

Authorization

I authorize the Archdiocese of Galveston-Houston to deduct all or part of the premiums from my pay and have read all benefits information. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

If I decline any coverage, I acknowledge that I have been given the opportunity to participate, but choose to NOT enroll. Further, I understand that unless I have an eligible qualifying life event, my elections are final, and I will not be able to change any of them until the next annual enrollment.

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Signature of Employee

Date Signed

HIPAA requires the Archdiocese of Galveston-Houston Medical and Dental Plan to notify you that a privacy notice is available by obtaining a copy on the Archdiocese of Galveston-Houston website or by contacting our Benefits Department. Please contact the Benefits Hot Line at 713-652-8265 if you have any questions.

Additional Benefit Enrollment Information

A. Medical and Dental Information

Important Dependent Notice: If adding dependent(s) coverage to the Archdiocesan Health Plan, you must provide documentation that demonstrates eligibility, including but not limited to: Marriage Certificate along with either a copy of your most current Federal Tax Form or other Financial Documents, Birth Certificates, Court Orders or in case of pending adoption, Adoption Agency or Government Placement Papers showing imminent adoption. Any person knowingly and with intent to defraud Blue Cross Blue Shield of Texas is committing a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

B. Supplemental Life Information

Employee Coverage: You may elect coverage in \$25,000 increments, up to \$100,000. You may not exceed five times your basic pay. **Guaranteed Issue amount ONLY available for New Hires:** up to \$100,000 if under age 65. Coverage reduces at age 65 to 67% and at age 70 to 50% of the amount insured for. All other employees who are increasing coverage must complete the Evidence of Insurability form.

Child Coverage: Election of coverage provides \$10,000 for *each* eligible unmarried child. In order to elect Child Coverage you must first elect Employee Coverage.

C. Supplemental Life Rates

Employee Supplemental Life Insurance under age 65 - Bi-Weekly Premium (Increments of \$25,000 up to \$100,000)

Rates per \$1000 in multiples of \$25,000 up to \$100,000

Employee Under Age 65	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
\$25,000	\$0.48	\$0.58	\$0.77	\$0.88	\$0.97	\$1.45	\$2.24	\$4.18	\$6.40
\$50,000	\$0.97	\$1.15	\$1.55	\$1.75	\$1.94	\$2.91	\$4.48	\$8.35	\$12.81
\$75,000	\$1.45	\$1.73	\$2.32	\$2.63	\$2.91	\$4.36	\$6.72	\$12.53	\$19.21
\$100,000	\$1.94	\$2.31	\$3.09	\$3.51	\$3.88	\$5.82	\$8.95	\$16.71	\$25.62

Employee Supplemental Life Insurance for age 65 or older - Bi-Weekly Premium

Employee 65-69	\$16,750	\$33,500	\$50,250	\$67,000
Employee 70+	\$12,500	\$25,000	\$37,500	\$50,000
65-69	\$8.26	\$16.41	\$24.77	\$33.03
70-74	\$13.78	\$27.57	\$41.35	\$55.13
75+	\$13.78	\$27.57	\$41.35	\$55.13

Coverage Reduced to 67%

Coverage Reduced to 50%

Child Voluntary Life Insurance - Bi-Weekly Premium for \$10,000 Coverage

Child(ren)	Up to age 26
Up to Age 26	
\$10,000	\$0.57