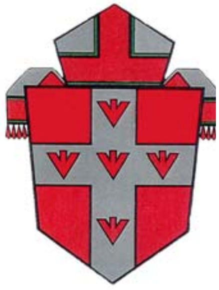

Archdiocese of Oklahoma City

Employee Health & Accident Plan Enrollment Form

Please complete all sections of this form. Incomplete forms will delay your enrollment.

Name:			**Social Security #:**		
Date of Birth:		**Gender:**	☐ Male ☐ Female	**Email Address:**	
Home Address:			**City:**	State	
State:			**Zip Code:**		
Phone #:	( )	**Date of Hire:**		**Work Location:**	
Employee Classification:	☐ Lay Employee (includes Seminarians) ☐ Contracted Teacher ☐ Non-Contracted School Employee		☐ Sister (Religious) ☐ Priest (Diocesan or Order) ☐ Retired Priest ☐ Other ______		
Coverage Effective Date:			**Salary:**		

This enrollment form contains your benefit options. **Costs shown are Monthly.** For questions regarding the completion of this form, please contact Dena Stone at Gallagher Benefit Services, 405-471-5013 or Shannon Schrempp at the Archdiocese of Oklahoma City Business Office, 405-721-5651, ext. 146.

Please mark your selections in the box provided to the right of each section.

MEDICAL/RX/DENTAL

Plan Options	Employee Only Cost	Employee + Family Cost	Medical/RX/Dental Option Selected	
Medical/RX	$0.00	$426.00	☐ Employee Only Medical/RX ☐ Employee + Family Medical/RX ☐ Waive Medical/RX Only	☐ Employee Only Dental ☐ Employee + Family Dental
Dental	$0.00	$56.00		
NOTE: Waiver of Dental Coverage will not be allowed. If you do not select a dental enrollment option, you will be automatically enrolled in Employee Only Dental.				

BASIC LIFE/AD&D and LONG TERM DISABILITY – EMPLOYER-PAID INSURANCE FOR THE EMPLOYEE

- ✓ Employee Basic Life and AD&D Insurance coverage is provided at no cost to you. The benefit is equal to 1 times your Annual Compensation (maximum $50,000).
- ✓ Employee Long Term Disability Insurance coverage is provided at no cost to you. The benefit is 60% of your monthly earnings to a maximum benefit of $6,000 per month. Benefits begin the day following completion of a 90 elimination period.

LIFE/AD&D – DESIGNATION OF BENEFICIARY

This beneficiary election is effective as of the signature date on this form. This designation applies to the Basic Life and AD&D paid by your employer and any Employee Voluntary Life election. The Employee is the beneficiary for any voluntary spouse or dependent life insurance.

Primary Beneficiary	First & Last Name	Social Security Number	Home Address	Relationship	Date of Birth	%
1.						
2.						
Contingent Beneficiary	**First & Last Name**	**Social Security Number**	**Home Address**	**Relationship**	**Date of Birth**	**%**
1.						
2.						

VOLUNTARY LIFE INSURANCE (EMPLOYEE PAID): Your monthly cost is listed below. Rates are subject to change on significant birth years.

Employee per $10,000	Employee Cost	Spouse per $5,000	Spouse Cost	Dependent Child Benefit	Dependent Child Cost
<25	$0.70	<25	$1.12	$2,000	$0.64
25-29	$0.53	25-29	$0.68	---	---
30-34	$0.63	30-34	$0.89	---	---
35-39	$0.83	35-39	$1.17	---	---
40-44	$1.33	40-44	$1.55	---	---
45-49	$2.43	45-49	$2.57	---	---
50-54	$4.14	50-54	$4.26	---	---
55-59	$6.23	55-59	$6.26	---	---
60-64	$7.75	60-64	$10.02	---	---
65-69	$14.48	65-69	$19.38	---	---
70-74	$25.70	70-74	$35.15	---	---
75+	$57.92	75+	$63.31	---	---
Employee - Increments of $10,000 up to $500,000 or 5x Salary Spouse – Increments of $5,000 up to $250,000 Child – Increments of $2,000 up to $10,000				---	---

Voluntary Life Option(s) Selected

- ☐ Elect Employee Voluntary Life Insurance
  Amount of Coverage Requested
  $_______________
- ☐ Elect Spouse Voluntary Life Insurance
  Amount of Coverage Requested
  $_______________
- ☐ Elect Dependent Child Voluntary Life Insurance
  Amount of Coverage Requested
  $_______________
- ☐ Waive – Employee Voluntary Life
- ☐ Waive – Spouse Voluntary Life
- ☐ Waive – Dependent Child Voluntary Life

VOLUNTARY SHORT TERM DISABILITY (EMPLOYEE PAID): *Benefit is 60% up to a maximum of $3,000 per month*

Rate per $10 of your salary	Monthly Benefit	Your Cost Per Month	2009 Voluntary Short Term Disability Option Selected
Age 15-24 =$0.83, Age 25-29 =$0.94, Age 30-34=$0.76, Age 35-39=$0.60, Age 40-44=$0.55, Age 45-49=$0.52, Age 50-54= $0.61, Age 55-59=$0.79, Age 60-64=$0.95, Age 65-69=$1.07, Age 70+ =$1.07	$	$	☐ Elect Voluntary Short Term Disability ☐ Waive

VOLUNTARY VISION (EMPLOYEE PAID):

Benefit	Employee Only Cost	Employee + Family Cost	2009 Vision Option Selected
Vision	$7.95	$17.50	☐ Employee Only Vision ☐ Employee + Family Vision ☐ Waive

CURRENT DEPENDENT INFORMATION –

Complete dependent information and mark an X in the box under the benefit column you wish for that dependent to be enrolled

Dependent Information & Coverage Elections

Relationship	Name		Date of Birth	Social Security Number	Gender	Medical	Dental	Vision	Vol. Life
						☐	☐	☐	☐
						☐	☐	☐	☐
						☐	☐	☐	☐
						☐	☐	☐	☐
						☐	☐	☐	☐
						☐	☐	☐	☐

Comments:____

____

____

I hereby authorize payroll deductions for the coverage(s) I have selected. I understand that if I do not elect voluntary coverage(s) at this time for myself and do not elect available coverage for eligible dependents, I waive my right to enroll for coverage(s) during the initial eligibility enrollment period. **I understand that I cannot make changes to my elections until the next annual enrollment period unless I have a qualifying event.**

Signature **Date**

Please return your completed form to the Business Office at the Archdiocese of Oklahoma City
P.O. Box 32180 Oklahoma City, OK 73123