ARCHDIOCESE OF NEW YORK

2025 HEALTH PLAN OPEN ENROLLMENT FORM

IF YOU ARE NOT MAKING ANY CHANGES TO YOUR CURRENT HEALTH COVERAGE, YOU DO NOT NEED TO COMPLETE A FORM

Employees requesting changes to their current coverage or those waiving coverage, MUST submit completed forms to their Local Benefits Administrator or Human Resources Coordinator prior to November 25, 2024. Failure to do so will result in your current coverage and elections remaining in place for the entire 2024 plan year. Late forms will not be accepted, no exceptions. All enrollments, changes, and waivers will be effective January 1, 2025.

ADMINISTRATOR USE ONLY - To be completed by Local Benefits Administrator/Human Resources Coordinator

Employee Status: ❑ Full-Time ❑ Part-Time Benefits Eligible **Regular Weekly Work Hours:** __________ **Employee Annual Salary: $**______________

Date of Hire: ____________ **Occupation:** ______________________________ **Covered by Collective Bargaining Agreement?** ❑ Yes ❑ No

Institution Name: ______________________________________ **Institution/Dept #:** __________/__________ **Division Code:** ______

Address: ____________________________________ **City:** __________________________ **State:** ____ **Zip Code:** _________

Employer Contact Phone Number: ____________________ **Employer Contact Email Address:** ________________________________

Employer's Signature (Required): ____ **Date:** ________________

Employer Print Name (Required): ____

Administrators: Please send completed form to Employee Benefit Connections at ebc@archny.org. For any questions or further assistance, please call (646) 794-3060.

For Clergy: For Clergy, please send completed forms to priestpersonnel@archny.org. For any questions or further assistance with Clergy, please call (646) 794-2934.

Employee Information – To be completed by the employee. Please complete Employee & Dependent Information Section on Page 2

Last Name: ______________________________ **First Name:** ______________________________ **MI:** ____ **Gender:** ❑ Male ❑ Female

Date of Birth: ___________ **SSN:** ________________ **Marital Status:** ❑ Single ❑ Married - Marriage Date__________ ❑ Divorced ❑ Widowed

Address: ______________________________ **Apt. #:** _____ **City:** __________________________ **State:** ____ **Zip:** ________

Home Phone: ________________ **Cell Phone:** ________________ **Email Address:** ______________________________

Dependent Information: For each plan, please list the name(s) of eligible dependent(s) to be covered (spouse/children). A child is considered a dependent until the end of the month in which they reach age 26. A Continuation of Coverage Enrollment Form will automatically be mailed to dependent children prior to reaching age 26 (Continuation of Coverage is not available for Dental or Vision).

Disabled Child: To apply for extension of coverage for a disabled child before the child reaches the limiting age of 26, please contact the benefit office.

Documentation: Proof of each dependent's eligibility must be attached to this form. For your spouse, attach a copy of your marriage certificate; for each child, attach a copy of his/her birth certificate, adoption, or legal guardianship documents.

Health Plan Coverage: Medical (United Healthcare) & Prescription (CVS/Caremark) – Please refer to the Health Plan Rate Sheet for the Cost							
Payroll Contribution Election: *I authorize the following deductions from my paycheck:*					❑ Pre-Tax Basis		❑ Post-Tax Basis
Add	Remove	Employee/Dependent Full Name	Sex	Date of Birth	Relationship to Employee	Social Security #	Disabled?
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No

Dental Plan Coverage: CIGNA Dental Preferred Provider Organization (PPO) – Please refer to the Dental Plan Rate Sheet for the Cost							
Add	Remove	Employee/Dependent Full Name	Sex	Date of Birth	Relationship to Employee	Social Security #	Disabled?
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No

Vision Plan Coverage: DAVIS Vision – Please refer to the Vision Plan Rate Sheet for the Cost							
Add	Remove	Employee/Dependent Full Name	Sex	Date of Birth	Relationship to Employee	Social Security #	Disabled?
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No
❑	❑		❑M ❑F				❑Yes ❑No

EMPLOYEE SIGNATURE: My signature below affirms eligibility for coverage, and authorization to deduct any and all contributions from my paycheck. All information provided is complete and true to the best of my knowledge. Any person who knowingly and with intent to defraud, submits an application for health, dental, or vision benefits 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 act, which subjects such person to civil penalties. If retired or otherwise not actively at work, I agree to pay the applicable premium required or portion thereof within 30 calendar days of the premium due date.

Employee Signature (Required): ______________________________ **Date:** ______________

Last Name: ______________________________ **First Name:** ______________________________ **MI:** ____