ROMAN CATHOLIC DIOCESE OF BURLINGTON

Health and Welfare Benefit Plan Enrollment Form

This form must be completed within 30 days of the date of initial eligibility or Qualifying Life Event, or the employee will forfeit the right to enroll in certain benefits until the next open enrollment or the employee experiences a Qualifying Life Event as defined by the IRS. Please send your completed form to Human Resources at humanresources@vermontcatholic.org or Human Resources, 55 Joy Drive, South Burlington, VT 05403.

Section I: Start Date and Changes

Employer Name (RCD, VCC, Parish or School):_____

_____ (Unless otherwise noted, benefits begin the first day of the new month after date of hire or the first day of the month after the employee enters a benefits eligible employment status.)
Date Benefits Begin

Employee Name (Last, First, Middle Initial):_____

☐ Please check this box if you are keeping the same benefits in 2024 as you had in 2023. Checking this box means you are not adding nor removing any dependents, and you are not changing coverage. By checking this box you can skip ahead to section 5.

☐ Please check this box if you would like to make changes to your benefits in 2024. Please continue to fill out sections 2 through 5.

Section 2: Employee Information

_____ ___-___-____ __/__/____
Last Name First Name Middle Initial SSN Date of Birth

_____ _____ _____
Street Address / P.O. Box City State, Zip

(___) ___-_____ _____
Phone Number Email

_____ _____
Gender Relationship Status: Single, Married, Divorced

Section 3: Employee's Spouse / Dependent Information

Please list ALL persons who qualify as your dependents:

Dependent Name (Last, First, MI)	Gender	Relationship*	Date of Birth	SSN
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Relationship: Spouse, Child, Stepchild, Foster Child*
Child Status: If child is age 26+ coverage is available only if child is disabled.

I attest that the person(s) listed above are my dependents as defined by the IRS and I certify that I can provide proof of dependent status (valid marriage certificate, birth/adoption certificate, etc.) if requested to do so. I further agree to notify Human Resources within 30 days of a change in family status that may affect benefits eligibility.

_____ _____
Signature Date

Section 4: Medical, Dental, and Vision Coverage

Medical Coverage: ☐ Single ☐ Employee and Spouse ☐ Employee and Children ☐ Employee and Family
Medical Plan Type: ☐ Platinum Plan ☐ Gold Plan ☐ Silver Plan

List the Names of the Spouse/Dependents for Medical Coverage: _____

Dental Coverage: ☐ Single ☐ Two Person ☐ Family
Dental Plan Type: ☐ High Option Plan ☐ Low Option Plan

List the Names of the Spouse/Dependents for Dental Coverage: _____

Vision Coverage: ☐ Single ☐ Two Person ☐ Family

List the Names of the Spouse/Dependents for Medical Coverage: _____

Section 5: Signature

I received a benefits packet, or I have opted to access the benefits information electronically (via email or at www.vermontcatholic.org). I have also received current rate information for the benefits programs mentioned on the current benefits rate sheet. I agree to: 1) abide by the terms outlined in the materials provided; 2) have the appropriate employee contributions withheld from my pay; 3) confirm that the correct deductions are withheld from my pay and agree to deduction corrections if necessary; and 4) notify Human Resources within 30 days of a Qualifying Life Event (for example: marriage, divorce, birth of a child, child custody change, dependent child turns age 26, etc.) that may affect benefit eligibility.

I understand that failure to promptly notify Human Resources of a Qualifying Life Event may result in loss of benefit coverage, forfeiture of COBRA rights (after 60 days), personal financial liability for claims paid on behalf of an ineligible family member, inability to change pre-tax deduction level to reflect loss of coverage, inability to add dependents. I understand that I will not be able to change my benefit elections until the next annual open enrollment, unless I have an eligible Qualifying Life Event as defined by the IRS.

_____ _____
Employee Signature Date