Diocese of La Crosse
Lay Ministry Benefits
Employer & Participant Information

Group # L06588

Employer Information

Employer Name (Parish-School-Institution)

DOL Location #

City

Participant Information

Participant First Name

Participant Last Name

Participant MI

Street Address

City

State

Zip

Phone Number

Personal Email

Birth Date

Social Security Number

Gender

Male

Female

Status

Single

Married

Employment Information

Classification

Full Time Year-Round

Full Time - School Year

Part Time Year-Round

Part Time - School Year

Hour Per Week

Hire Date

First Day Of Work

Job Title

Enrollment Status Information

Status Type
Please select one

New Employee
Eligible the first month, following the first day of work. New employees need to complete this manual in its entirety.

Open Enrollment
This box should only be checked during an open enrollment event. Benefits to begin January 1st.

Changes
Please complete the changes page of this manual. Changes include updating personal information, adding or dropping a dependant, and declaring a qualifying event.

Termination
Termination, Resignation & Retirement

Resignation Date

Last Day of Work

Reduction of Hours

Increase of Hours

New Hours Per Week

Start Date of New Schedule

Changes
Personal Information, Dependents and Qualifying Events

Personal Information Change

☐ Name Change — Former Name — New Name

☐ New Address — Street Address — City

State — Zip

☐ Other Change — Phone Number — Personal Email

Job Title — Marital Status Change

Qualifying Event
Please Select The Correct Qualifying Event And Indicate The Event Date
If The Qualifying Event Effects Your Dependants, Be Sure To Fill Out The Dependant Page

☐ Marriage — Date of Wedding — Marriage Coverage Election Date - Choose One: 1st Of The Month Following Wedding date or Wedding Date

☐ Birth — Birth Date of Child

☐ Divorce — Date of Decree

Payroll Information
Was the employee contribution deducted from payroll pre-tax or post-tax?

☐ Loss of Coverage — Last Day of Coverage — Reason — Support Document Acquired

☐ New Eligible Coverage — 1st Day of New Eligible Coverage

Please Note: Open enrollment for the "Market Place" or your spouse's plan does NOT qualify as New Eligible Coverage. Please contact St. Ambrose for assistance navigating this situation.

Benefit Elections

Be Sure To Fill Out The Dependant Page If you Are Electing "Family" On Any Parts Below

Medical Plan Offerings

VSP Vision and CVS Caremark Is Included In the Medical Plan

Anthem

☐ "Traditional "- PPO ☐ "High Deductible" - HSA ☐ "The Max" Highest Deductible - HSA

☐ Single ☐ Family ☐ Waive Coverage _ Payroll Election

Vision Election

This Section does not need to be completed when electing Family Medical.

☐ Single ☐ Family ☐ Waive Coverage _ Payroll Election

Dental Election

☐ Single ☐ Single +1 ☐ Family ☐ Waive Coverage _ Payroll Election

Other Insurance Coverage Q&A

As of your effective date, will there be any other insurance in effect on you or any dependents to be covered? _

Did You Answer Yes? If Yes, Please Complete Next Section

Primary Insured Name	*Medical Carrier*	*Group/Policy Number*	*Effictive Date*	**Single/Family**
				_

Dependents Covered - First & Last Name - One Dependent Per Box

Other Coverages In Effect

_ Dental	_ Single/Family
_ Vision	_ Single/Family

Dependants

Please Use This Page To Declare Dependants
Enrollment & Qualifying Events

Spouse/Child	First Name	Last Name	MI	Social Security Number	Birth Date	Gender	Add/ Drop	Health	Vision	Dental
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_
_						_	_	_	_	_

Basic Life
Accidental Death/ Dismemberment

Participant Must Elect This Benefit OR Waive At The Start Of Employment. Election AFTER the original employment window is NOT Guaranteed. An Evidence Of Insurability Will Be Requested To Enroll In Basic Life And Be Determined by The Hartford Insurance Group.

Election

$30,000 Flat Coverage

Life Reduction Rate - Your Benefit Will Be Reduced By 35% At Age 65 And 50% At Age 70. Reductions Applied To The Original Amount

☐ Elect ☐ Waive

Beneficiary

Primary Beneficiary _____ Relationship _____

Contingent Beneficiary _____ Relationship _____

Spousal Consent

Community Property State Consent for Wisconsin Residents

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 this 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 _____

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.

Participant Signature (Required)	Date

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 the FIRST DAY OF WORK 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.

Contact Us With Questions:

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

Elections

☐ Life

☐ Waive

Post-Tax

Payroll

☐ Disability

☐ Waive

Post-Tax

Payroll

Plan Administrative Information

How Many Hours A Week Do You Work?

How Many Hours In A Year Do You Work?

_

Are You Hourly or Salaried?

Enter Hourly Rate or Yearly Salary

Benefits Enrollment Form for Diocese of La Crosse
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Employer Use (Check One):

☐ **New Employee**

☐ **Change**

Instructions: 1) Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Please review the applicable benefit highlight/summary information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable group policy. **3)** For each coverage, please check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. **4)** Please sign and date the form. **5)** Submit the form as instructed by your benefits administrator by the enrollment deadline. (Do not submit or send the form directly to The Hartford.)

EMPLOYEE INFORMATION

Name (FIRST MI LAST)		**Date of Hire** (MM/DD/YYYY)	**Date of Birth** (MM/DD/YYYY)
Social Security Number	**Phone Number**	**Address**	
Job Title	**Hours/Week**	**Earnings** $ ☐ **Hourly** ☐ **Weekly** ☐ **Monthly** ☐ **Annually** ☐ **Other** _____	

DEPENDENT INFORMATION (ADDITIONAL CHILDREN MAY BE LISTED ON SEPARATE PAPER AND ATTACHED TO/SUBMITTED WITH THIS FORM)

Spouse Name (FIRST MI LAST) ☐ N/A	**Date of Birth**	**Gender** ☐ M ☐ F	**Date Married**

Child Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Child Name** (FIRST MI LAST)	**Date of Birth**	**Gender**
		☐ M ☐ F			☐ M ☐ F
		☐ M ☐ F			☐ M ☐ F

VOLUNTARY LONG TERM DISABILITY INSURANCE

Coverage for Employee Only	**Benefit Amount**	**Monthly Premium Amount** (Cost per Pay Period – 12/Year)	**Elect Coverage or Continue Current**	**Decline Coverage**
Employee	60% of earnings, up to $5,000 each month	$ _____	☐	☐

Additional Information:

- Your benefit amount is based on your earnings; therefore, your benefit and premium amount will change as your earnings change.
- Your premium amount is based on your age; therefore, your premium amount will change, as you grow older.

SUPPLEMENTAL TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

You must enroll for this coverage in order for your dependents to be eligible for this coverage.

Coverage for Employee Only	Benefit Amount – Select One Option	Monthly Premium Amount (Cost per Pay Period – 12/Year)
Employee	☐ $10,000	$_____
	☐ $20,000	$_____
	☐ $150,000	$_____
	☐ $500,000 (Requires EOI*)	$_____
	☐ $_____	$_____
	☐ Decline Employee Coverage	N/A
Spouse	☐ $5,000	$_____
	☐ $10,000	$_____
	☐ $50,000	$_____
	☐ $100,000 (Requires EOI*)	$_____
	☐ $_____	$_____
	☐ Decline Spouse Coverage	N/A
Child(ren) • The premium amount(s) shown apply to all children, regardless of the number of children you have	☐ $10,000	$1.90 for all children
	☐ Decline Child(ren) Coverage	N/A

Additional Information:

- *If you elect an amount that exceeds the guaranteed issue amount of $150,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.
- *If you elect an amount that exceeds the guaranteed issue amount of $50,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.
- The premium amount(s) for you and your spouse are based on your (employee) age; therefore, the premium amount(s) will change as you grow older.
- The benefit amount available to you and your spouse under this plan is subject to a reduction schedule beginning at age 65.
- The child benefit amount listed applies to any child age 15 days or older.

BENEFICIARY DESIGNATION (PLEASE ENSURE YOUR BENEFICIARY DESIGNATION IS CLEAR SO THERE IS NO QUESTION OF YOUR INTENT)

This designation is for **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of your death, unless otherwise requested by you in writing. This designation may be changed upon written request. **All** information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. The **percentages must total 100%** for all Primary Beneficiaries and 100% for all Contingent Beneficiaries. If you need to designate more beneficiaries than space will allow, please include the additional information on a separate paper and attach it to/submit it with this form, clearly stating your name. Please consult your benefits administrator or legal advisor for assistance or additional information.

Certain states are community property states. If you live in one of these states – AK, AZ, CA, ID, LA, NV, NM, TX, WA or WI – and designate someone other than your spouse as your beneficiary, state law may require that your spouse consent to the designation. Puerto Rico and certain tribal jurisdictions may also require spousal consent. Spousal consent may not apply to ERISA plans. Please consult your benefits administrator or legal advisor for additional information.

Primary Beneficiary(ies) (PRIMARY BENEFICIARIES ARE FIRST IN LINE TO RECEIVE BENEFITS IF LIVING AT THE TIME OF YOUR DEATH)				
1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
Contingent Beneficiary(ies) (CONTINGENT(S) WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS ALIVE AT THE TIME OF YOUR DEATH)				
1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

CONFIRMATION & SIGNATURE

By signing below:

- I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.
- I understand and agree that: 1) If I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) Only the insurance policy(ies) issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy; 6) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 7) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- I have read and understand the “Important Notice – Fraud Warning Statements” that applies to my state of residence.

Employee Signature	**Date of Signature**

END OF FORM – PLEASE REVIEW THE “IMPORTANT NOTICE – FRAUD WARNING STATEMENTS” ON THE FOLLOWING PAGE

Benefits Enrollment Form
Important Notice – Fraud Warning Statements
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Please read the statement that applies to your state of residence prior to signing the enrollment form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For residents of New Mexico and North Carolina: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be submit to civil fines and criminal penalties.

For residents of New York (not applicable to Life Insurance applications in New York): 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oregon: 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

EMPLOYEE NAME:_____

1. Verify Information Is Correct
    a. Location Name
    b. Location Number
    c. Dates
    d. Elections
    e. Signatures
2. Submit Copy To Payroll
3. Submit Copy To St. Ambrose
    a. Secure Email
    b. Secure Portal Upload
    c. Fax
4. Retain Original In The Employee File