Employer Information

Employer Name (Parish - School - Institution)

DOL Location #

Diocese of La Crosse

Lay Benefits

Employer & Participant Information

Change From - Qualifying Event

Group # L06588

SAFS Use Only - Effective Date

Qualifying Event

Please Choose One Qualifying Event From The List Below And Complete The Following Pages As Needed

Event -Please Select One

◯ Open Enrollment - **Please Complete The Following Page**

◯ Reduction of Hours — **New Hours Per Week** — **Start Date of New Schedule** — **Please ONLY Complete Participant Information On Next Page**

◯ Increase of Hours — **New Hours Per Week** — **Start Date of New Schedule** — **Please Complete The Following Page**

◯ Marriage — **Date of Wedding** — **Election Choice** ◯ Date of Wedding ◯ 1st of The Month After The Wedding — **Please Complete The Following Page**

◯ Loss of Coverage — **Reason** — **Last Day of Coverage** — **Please Complete The Following Page & Submit Support Documents To SAFS**

◯ Divorce — **Date of Decree** — **Please Complete The Following Page**

◯ Birth Of A Child — **Date Of Birth**

◯ Termination — **Resignation Date** — **Last Day of Work** — **Please ONLY Complete Participant Information On Next Page**

◯ New Eligible Coverage — **1st Day of New Eligible Coverage** — **Please Complete The Following Page**

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.

Employer Information

Employer Name (Parish - School - Institution)

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Diocese of La Crosse
Lay Ministry Benefits
Employer & Participant Information

Change From - Qualifying Event -New Elections

Group # L06588

SAFS Use Only - Effective Date

Participant Information

First Name | **Last Name** | **MI** | **Phone Number** | **Social Security Number**

Street Address | **City** | **State** | **Zip** | **Personal Email**

Birth Date | Male Female | Single Married | Full Time Year-Round | Part Time Year-Round | Full Time School-Year | Part Time School-Year | **Job Title** | **First Day Of Work** | **Hours Per Week**

Benefit Elections

Please Select One From Each Election. If you Waive Medical, Skip Plan Selection

Medical: Single | Family | Waive

Plan: Traditional | High Deductible HSA | "The Max" HSA

Vision *Included With Medical*: Single | Family | Waive

Dental: Single | Single+1 | Family | Waive

Dependents

Spouse Or Child	First Name	Last Name	MI	Social Security Number	Birth Date	Male	Female	Medical	Vision	Dental

Other Insurance Coverage

As of your effective date, will there be any other insurance in effect for you or any dependents listed above? If Yes, Please Complete Below

Primary Insured	Medical Carrier	Policy - Group Number	Effective Date	Single	Family	Vision	Dental

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

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 a qualifying event or family status change.

Participant Signature - Required

Date