Diocese of Raleigh

Employee Benefits Election Enrollment Form

(Please submit completed form to Benefits Administrator at Benefits.forms@raldioc.org or via fax 984-275-1726)

◯ **EMPLOYEE NOT ELIGIBLE** ***(based on EE type/status)*** ◯ **EMPLOYEE DECLINES BENEFITS** ◯ **EMPLOYEE ELIGIBLE BUT UNDECIDED (31 days)**

Benefits Election Enrollment Form

Benefit Coverage Start Date: _____

Coverage begins the first of the month following first day of work, unless first day of work is the first day of the month - then it begins on that day.

Company/Location: Catholic Center (Raleigh)

Employee Information

Employee ID # _____ **First Name** _____ **Last Name** _____

Benefit Plans

Make your selection from the plans below. If coverage includes dependents (spouse or child(ren)), dependent information section must be completed for each covered member.

Medical

(Vision coverage is included at no additional cost to the employee when enrolled in the medical plan)

◯ Employee **Declines** Medical (+Vision) Coverage

◯ Employee Only Medical (+Vision)
◯ *Employee and Spouse Medical (+Vision)
◯ *Employee and Children Medical (+Vision)
◯ *Employee and Family Medical (+Vision)

26 Pay and 20 Pay Full-Time Employee benefits include:

- Medical (+Vision)
- Dental
- Group Term Life
- 403(b)
- 403(d) - 4% employer contribution
- 403(m) - Match employee contribution (see plan for details)

403(b) changes must be made by the employee via Lincoln Financial Group's website

Dental

◯ Employee **Declines** Dental Coverage

◯ Employee Only Dental
◯ *Employee and Spouse Dental
◯ *Employee and Children Dental
◯ *Employee and Family Dental

*Dependent Information

If applicable- must be submitted if coverage is requested for spouse, child/ren, or family coverage.

	Name	SSN	DOB	Gender M/F	Legal Guardian?	Step-Child?	Disabled Veteran?
					If any of these apply, check box in column		
Spouse							☐
Child(ren)							
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

Additional dependents may be submitted on a separate sheet of paper (include all information).

CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax

Request for Group Coverage/Enrollment Form

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain provisions contained within this plan may or may not apply while you are covered. PLEASE READ THE FOLLOWING CAREFULLY.

Special Enrollment Rights

If you waive (or decline) enrollment for yourself or your dependents because of other health coverage, you may later enroll within 31 days of a loss of other health coverage. Loss of health coverage includes separation, divorce, death, termination of employment, reduction in work hours, exhaustion of COBRA continuation or state continuation, or if employer contributions toward your coverage have terminated.

In addition, any change in your family status may allow you to enroll within 31 days of the event. It includes marriage, birth, adoption, or placement for adoption of a child. (See Special Enrollment Form)

With the Onset of the **Children's Health Insurance Program Reauthorization Act of 2009** two additional enrollment opportunities apply for CBEBT Trust members and their enrolled dependents if either of the following occurs:

- Termination of Medicaid or Children's Health Insurance Program **(CHIP)** due to loss of eligibility; or
- Become eligible for state premium assistance under Medicaid or **CHIP**.

Trust members and their dependents who are eligible but not enrolled for coverage under the Christian Brothers Employee Benefit Trust are allowed up to **60 days** to request coverage under the group health plan.

Complete forms >

Please contact your employer for any clarification regarding your enrollment in the CBEBT.

Please read and fill out ALL applicable sections carefully.

Employer Section

Location Name	Location Number	First Active Day of Work	**Enrollment Use Only** Effective Date of Coverage

Annual Salary	Occupation

Employee Section

Employee's Name (Last, First, Middle Initial)	Employee's Social Security Number	Date of Birth

Employee's Home Street Address	City	State	Zip Code

Email Address	Phone Number

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Religious

I request to be covered for the applicable benefits of my Group Plan as:

☐ Employee Only or ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee, Spouse and Child(ren)

Dependent Information *Please complete section below if selecting dependent coverage. Must be completed entirely or can result in delay.*

Spouse's Name (Last, First, Middle Initial)	Social Security Number	Date of Birth	
			☐ Male ☐ Female

List Dependent Children Below

Dependent's Name(s) (Last, First, Middle Initial)	Social Security Number	Date of Birth	Sex	Are You the Legal Guardian	Step-Child	Disabled Dependent
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee Signature	Date

Waiver of Group Coverage

I hereby certify that I have been given an opportunity to apply for group coverage. I understand that if I waive coverage at this time, future coverage may be delayed. I decline to enroll:

☐ Myself ☐ My Dependents for Coverage(s) ***Because:*** ☐ Enrolled on Spouse's Plan ☐ Individual Policy ☐ Medicare ☐ Medicaid

☐ Enrolled with another employer plan ☐ Other, Please Explain ______________________________

Signature of Employee	Date	Effective Date

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PLEASE NOTE: Do Not Use This Form to Change the Beneficiary Designation.

Life Insurance

Employer Name	Location Number	Employee's Name (Last, First, Middle Initial)

Employee's Social Security Number

Primary Beneficiary Designation (If additional beneficiaries, please attach additional page)

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Share %

Payment will be made in equal shares or all to the survivor unless otherwise indicated.
In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies)

Contingent Beneficiary Designation (If additional beneficiaries, please attach additional page)

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Share %

Payment will be made in equal share or all to the survivor unless otherwise indicated. If no beneficiary or contingent beneficiary designated shall be living following the insured's death, the amount payable by reason of the insured's death shall be payable as provided in the Group Policy.

Signature of Employee	Date

Popular Beneficiary Designations on Next Page >

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Popular Beneficiary Designations

Be sure to use given names such as “Mary M. Doe”, not Mrs. John Doe”. The following sample designations may be helpful to you.

Type of Beneficiary	Standard Wording
1. insured’s estate	my estate
2. one beneficiary	Anna L. Doe wife
3. two beneficiaries	John A. Doe, father, and Mary I. Doe, mother, equally or to the survivor
4. three or more beneficiaries	John A. Doe, father, and Mary I. Doe, mother, and Henry J. Doe, son, equally or to the survivor(s)
5. one beneficiary and one contingent beneficiary	Anna L. Doe, wife, if living; otherwise, Henry J. Doe, son
6. one beneficiary and two or more contingent beneficiaries	Anna L. Doe, wife, if living, otherwise Henry J. Doe, son, Alice G. Doe, daughter, equally or to the survivor
7. one beneficiary and three or more contingent beneficiaries	Anna L. Doe, wife, if living, otherwise Henry J. Doe, Alice G. Doe and Charles B. Doe, children, equally or to the survivor(s)
8. two beneficiaries and one contingent beneficiary	John A Doe, father, and Mary I. Doe, mother, equally or to the survivor; otherwise, Anna L. Doe, wife
9. two beneficiaries in unequal portions	three-quarters of the proceeds to John A. Doe, father, if living, and one-quarter to Anna L. Doe, mother, if living, the share of a deceased beneficiary to be paid to the survivor, if any
10. trust with individual trustees	Richard Doe and John Smith, trustees, or a successor in trust under (trust name) established (date of trust agreement)
11. present or living trust	ABC Bank and Trust Company, Des Moines, Iowa, trustee or successor in trust under (trust name) established (date of trust agreement), provided however that the company has received within 180 days of the death of the insured, evidence satisfactory to the existence of such trust; otherwise to the estate of the insured.
12. testamentary trust	Trustee of the Mary L. Doe trust or successor in trust established by the last will and testament of the insured

dated.....

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Other Coverage/ Authorization To Release Information

As a new member of the Christian Brothers Employee Benefit Trust, it is necessary for you to complete the information requested below. Failure to do so will result in a delay in processing your initial request for benefits.

Employee Name (Last, First, Middle Initial) | Location Number | Social Security Number

Home Street Address | City | State | Zip Code

Other Coverage Information

Please check one of the following categories and provide the requested information if it applies.

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Religious

Spouse's Name (Last, First, Middle Initial) | Spouse's Date of Birth | Spouse's Social Security Number

Do you have any additional Employers? ☐ Yes ☐ No
If yes, please provide employer name, address and telephone number.

Do you have any other coverages (including AARP)? ☐ Yes ☐ No
If yes, please provide employer name, address and telephone number.

Do your dependent children (if any) have any other coverages (including AARP)? ☐ Yes ☐ No
If yes, please provide employer name, address and telephone number.
(Please attach additional information if other coverage is not applicable for all dependent children)

Is your spouse employed? ☐ Yes ☐ No
If yes, please provide employer name, address and telephone number.

Spouse's other coverage (including AARP)? ☐ Yes ☐ No
If yes, please provide employer name, address and telephone number.

Any Change in Other Coverage Information Must be Reported to Our Office

I Hereby Certify That All Information, Statements and Answers Made on This Form are Complete and True to the Best of my Knowledge.

Employee Signature | Date

Authorization to Release Information: I authorize any physician, hospital, or other health care provider to release to Christian Brothers Employee Benefit Trust, or its representative, any information regarding my medical history, symptoms, treatment, examination results, or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for one year from the date signed. I understand I have a right to receive a copy of this authorization.

Employee Signature | Date

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Christian Brothers Employee Benefit Trust History

The **Christian Brothers Employee Benefit Trust (CBEBT)** was established on January 1, 1977, by the Christian Brothers. It began in 1966 as a collective effort to provide a comprehensive package of Employee Benefits to the employees of the Christian Brothers schools. As the news spread of the benefits and savings received by participating in a large group, it was opened in 1977 to any Catholic institution registered in the Kenedy Catholic Directory nationwide.

The CBEBT has evolved into a cooperative effort of Catholic organizations continuously working together to provide a package of benefits for their employees in a cost-effective manner.

The CBEBT is governed by a board of Trustees who have been elected by the members of the Trust. The Trustees have contracted with Christian Brothers Services to act as the Plan Administrator for the Trust. Health Solutions is the division of Christian Brothers Services that administers all the benefits plans funded by the Trust.

Christian Brothers Services Mission Statement

The Mission of Christian Brothers Services is to serve the Catholic Community by helping to fulfill organizational and managerial needs through the development of quality, cost-effective, innovative programs and administrative services.

We accomplish this mission in collaboration with other Catholic organizations by combining leadership and insight with the practice of good business principles and belief in the tenets of the Catholic Church.

Customer Service/Benefit Information... 800.807.0400