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.

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

Please read and fill out ALL applicable sections carefully. Form must be completed entirely or can result in a delay. Please print or type.
If you are Waiving medical coverage, ALL applicable* fields in Section 1 Must Be Completed.

1. Employee Information

*Location Name:		*Location #:	
*First Active Day of Work:		**Enrollment Use Only:** Effective Date of Coverage:	
Annual Salary:		Occupation:	
*Last Name:		*First Name:	
*Home Address:			
*City:		*State:	*Zip Code:
*Social Security #:		*Date of Birth:	
* Email Address:		* Home/Cell Phone:	

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

2. Benefit Election(s) or Waiver of Medical Coverage

I request to enroll myself and any applicable dependents below to the benefits my employer offers and following the group's "tiered" structure with the type of coverage as chosen here:

Who is to be Covered	Type of Coverage	Medical Plan Election
☐ Employee	☐ Medical ☐ Dental ☐ Vision	
☐ Employee + Dependents	☐ Medical ☐ Dental ☐ Vision	

** Spouse and Child(ren) cannot be enrolled in coverage(s) not selected by the employee, and Dependent coverage(s) must match **

Dependent Information

List the name of each dependent and answer each question for each dependent	Social Security Number	Birthdate MM/DD/YY	Sex M/F	Are you Legal Guardian	Step-Child	Disabled Dependent
Spouse:				N/A	N/A	N/A
List Children Below						

Waiver of Medical Coverage

I hereby certify that I have been given an opportunity to apply for medical coverage. I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a qualifying event/special enrollment opportunity or during the next open enrollment period. I decline coverage for:

☐ Myself ☐ Spouse ☐ Dependent Child(ren) ☐ Myself and all Dependents

because:

☐ Spouse's Plan ☐ Individual Policy ☐ Medicare ☐ Medicaid ☐ Enrolled with another employer plan

☐ Other; please explain:

Signature of Employee:		Date:	

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4. Other Coverage/ Authorization To Release Information

As a new participant 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:	
Social Security Number:	
Address:	

Other Coverage Information

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

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Religious

Spouse's Name:			
Spouse's Date of Birth:		Spouse's Social Security #:	

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 carrier name, address and telephone number.
Do your dependent children (if any) have any other coverages (including AARP)?	☐ Yes ☐ No	If yes, please provide carrier 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 carrier 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.	Signature (Employee): 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.	Signature (Employee): Date:

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 Benefit Services*** 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.

Important Phone Numbers

Customer Service/Benefit Information : 800.807.0400

Christian Brothers Health Benefit Services
1205 Windham Parkway, Romeoville, IL 60446-1679