The Benefits of Caring

Catholic Health Services of Long Island – Benefits Decision Form

Instructions: Please access www.benefitsquest.com/chsli for a description of benefits offered by your employer, and to the *Employee Contribution Rate Sheet* for a listing of your costs for the various benefits offered. Please print clearly. Return this form to the Human Resources Department.

I am a: ❑ **Full-time employee** ❑ **Benefit Eligible Part-time employee** **Organization/Location:**_____

***Qualified Status Change as of:** _____ **for:** _____
(date) (reason)

*All changes must be made within 31 days of the qualified status change (QSC) event. Please submit form & supporting documentation within 31 days of the QSC.

Employee Information:

Name: _____ **SSN:** _____ **Birth Date:** ___/___/____

Home Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Date of Hire:** _____ **Sex:** ❑ Male ❑ Female

Cell Phone: _____ **E-mail Address:** _____

Marital Status: ❑ Single ❑ Married **Employee #:** _____

Dependent Information:

You will be required to submit documentation to our third party vendor, Consova, for each dependent you are enrolling. You should receive a letter from Consova with instructions within 3 weeks of submitting your form. *If you do not submit appropriate documentation to Consova, your dependents will be removed retroactively to the benefit start date.*

Please print clearly.

	Add	Drop	Name:	SSN:	Birth Date:	Relationship:	Gender: Male	Female	Coverage: Medical	Dental	Vision
1.	❑	❑					❑	❑	❑	❑	❑
2.	❑	❑					❑	❑	❑	❑	❑
3.	❑	❑					❑	❑	❑	❑	❑
4.	❑	❑					❑	❑	❑	❑	❑

Name: _____

I wish to pay for Medical, Dental and Vision coverage: ❑ before-tax contribution ❑ after-tax contribution

Dental Coverage: (children are eligible for coverage until the end of the year in which they turn **25**)

❑ I wish to elect dental coverage. ❑ I **do not** wish to elect dental coverage.

- ❑ **Core:** ❑ Individual ❑ Family
- ❑ **Buy-Up:** ❑ Individual ❑ Family
- ❑ **DHMO***: ❑ Individual ❑ Family

***Please note:** If you elect the DHMO plan, you **must** call Cigna or log onto their website, www.cigna.com, and choose a dentist for each person enrolled.

Medical Coverage: (children are eligible for coverage until end of the year in which they turn **26**)

❑ I wish to elect medical coverage. ❑ I **do not** wish to elect medical coverage.

- ❑ **Empire POS*:** ❑ Individual ❑ Individual + 1 ❑ Family
- ❑ **Empire EPO:** ❑ Individual ❑ Individual + 1 ❑ Family
- ❑ **Empire PPO:** ❑ Individual ❑ Individual + 1 ❑ Family
- ❑ **Empire Select**:** ❑ Individual ❑ Individual + 1 ❑ Family

***Please note:** If you elect the POS plan, you **must** call Empire or log onto their website, www.empireblue.com, and choose a primary care physician for each person enrolled.

****The **Select Plan** is **not** available to spouses who have access to benefits through their own employer.

BlueView Vision Plus Coverage:

(children are eligible for coverage until the end of the year in which they turn **25**)

❑ I wish to elect BlueView Vision Plus coverage.

❑ Individual ❑ Individual + 1 ❑ Family

❑ I **do not** wish to elect BlueView Vision Plus coverage.

Flexible Spending Account:

Health Care FSA:

Health Care FSA allows you to pay for medical, dental and prescription drugs expenses with pre-tax dollars.

Some eligible expenses include:

- Co-pays, co-insurance and deductibles - Prescription drugs - Eye exams - Dental exams
- Physical exams and medical screenings - Hospital Bills

I would like to deduct the following amount annually to be used towards my **Health Care FSA:** $_____

(maximum annual limit of $2,700)

Dependent Care FSA:

Dependent Care FSA allows you to pay for dependent care with pre-tax dollars. Dependents are defined as children under 13 years of age, or dependents who are physically or mentally unable to care for themselves. **Children are eligible up to their 13th birthday**.

Some eligible expenses include:

- Local day camp - Before-care and after-school childcare - Preschool

I would like to deduct the following amount annually to be used towards my **Dependent Care FSA:** $_____

(maximum annual limit of $5,000 if filing jointly; $2,500 if filing single)

Please Note: Benefit options elected will remain in force throughout the plan year unless you have a change in family status. CHS Health Plan, including the Healthcare FSA do not cover expenses for procedures or items that violate the ethical directives of the Roman Catholic Church.

Name: _____

Long Term Disability (LTD) Insurance Coverage:

- ❑ I wish to elect LTD Insurance coverage.
- ❑ I **do not** wish to elect LTD Insurance coverage.

Dependent Life Insurance for Spouse:

- ❑ I wish to elect Dependent Life Insurance for my spouse.

Spouse Name: _____

❑ $5,000 ❑ $20,000 ❑ $50,000 ❑ $100,000 ❑ $150,000

- ❑ I **do not** wish to elect Dependent Life Insurance for my spouse.

Dependent Life Insurance for Child(ren):

- ❑ I wish to elect Dependent Life Insurance for child(ren)*. *unmarried dependent children are eligible until the end of the year in which they turn age 26.

❑ $4,000 ❑ $10,000

- ❑ I **do not** wish to elect Dependent Life Insurance for my child(ren).

Short Term Disability (STD) Insurance Coverage:

- ❑ I wish to elect Short Term Disability Insurance coverage.

❑ $100 ❑ $200

- ❑ I **do not** wish to elect Short Term Disability Insurance.

Supplemental Life Insurance:

- ❑ I wish to elect Supplemental Life Insurance.

(per annual base salary)

❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x ❑ 6x

- ❑ I **do not** wish to elect Supplemental Life Insurance.

Please note: Proof of good health may be required for Supplemental Life Insurance, Dependent Life Insurance and for Long Term/Short Term Disability Coverage.

Life and Accidental Death & Dismemberment (AD&D) Beneficiary(ies) — The beneficiary designation(s) made below is(are) for all benefits payable under my employer's Life and AD&D Insurance plans, which automatically provide a benefit equal to one times your annual salary. This designation will cancel any previous designation. When I name more than one beneficiary, payment will be made in equal amounts, unless otherwise specified. Benefits will be paid to the Contingent Beneficiary if the Primary Beneficiary is deceased. In the event that all beneficiaries are deceased or no beneficiaries are on file, benefits will be paid as provided in the group policy. (If additional space is required, please attach a separate sheet.)

Beneficiary(ies)	Name (Last, First, MI):	Birth Date	SSN	Relationship to you	% of Benefit	Address (if different from your own)
❑ Primary		/ /				
❑ Primary		/ /				
❑ Contingent		/ /				

Employee Authorization and Acknowledgment

I declare that the information given above is true and complete to the best of my knowledge and that I am actively at work on the date of enrollment. I acknowledge that by signing and submitting this form, I authorize my employer to make the necessary payroll deductions to pay for my elected benefits. If I do not enroll in the health care programs at this time, I understand that I may enroll in the future only if I experience a Qualified Status Change or during the next Annual Enrollment Period. I also understand that if I waive participation in any of the above insurance options, no benefits can be paid for expenses that my dependents or I incur during the year. I understand further that, except with respect to any health care FSA and dependent care FSA elections I have made, and subject to my submission of any required dependent documentation, if I do not make a new election during the next Annual Enrollment Period, the above will continue in effect until changed by making a new election during a subsequent Annual Enrollment Period or until changed incident to a Qualified Status Change, and I hereby agree to any increases in my salary reduction in any subsequent periods of coverage to pay for any increases in the cost of coverage in such period(s).

Employee's Signature: _____ Date: _____

Name: _____

Coordination of Benefits

Please complete the following sections if you or your dependents have additional medical or dental insurance:

Additional **medical** coverage:

Name of Person:	Name of Insurance:	Date of Coverage	Provided by Employer?	Employment Status:	Type
Self:	Name: Phone: Policy #:	Begin: End:	❑ Yes ❑ No	❑ Active ❑ Retiree	❑ Individual ❑ Ind+1 ❑ Family
Spouse:	Name: Phone: Policy #:	Begin: End:	❑ Yes ❑ No	❑ Active ❑ Retiree	❑ Individual ❑ Ind+1 ❑ Family
Dependent 1:	Name: Phone: Policy #:	Begin: End:	❑ Yes ❑ No	❑ Active ❑ Retiree	❑ Individual ❑ Ind+1 ❑ Family
Dependent 2:	Name: Phone: Policy #:	Begin: End:	❑ Yes ❑ No	❑ Active ❑ Retiree	❑ Individual ❑ Ind+1 ❑ Family

Additional **dental** coverage:

Name of Person:	Name of Insurance:	Date of Coverage:
	Name: Phone: Policy #:	Begin: End:
	Name: Phone: Policy #:	Begin: End:
	Name: Phone: Policy #:	Begin: End: