THE DIOCESE OF SCRANTON

FOR EMPLOYER USE Qualifying Employee Event: ☐ New Hire ☐ Loss of Other Coverage ☐ Gain of Eligibility

☐ Open Enrollment Qualifying Dependent Event: ☐ Birth ☐ Marriage ☐ Loss of Other Coverage ☐ Support Order

Effective Date of Benefits: _____ Date of Hire: _____

EE Number: _____ EE Location: _____ Department: _____

*Employer Signature: _____ Date: _____

*Upon signature, the employer indicates that this form has been reviewed and all information is accurate.

ENROLLMENT CHANGE FORM – Notre Dame

Employee Information

Social Security Number	Last Name	First Name	MI

Address	City	State	Zip

Date of Birth	Gender	Phone Number	Email
	☐ M ☐ F		

Plan Elections –

	Employee Only	EE + Child	EE + Child(ren)	EE + Spouse	Family	Waiver*
Medical Plans						
Blue Care PPO	☐ $25.00	☐ $45.50	☐ $62.50	☐ $58.50	☐ $80.00	☐
*Reason for Waiving Medical Coverage: _____ I hereby certify that I and my eligible dependents have been given the opportunity to participate in the group health insurance plan offered by my employer. I understand that if I decide to apply for this coverage at a later date not related to a lifestyle change I and any eligible dependents will have to wait until the annual open enrollment period for enrollment. I understand I may be required to provide proof of other coverage.						
Dental Plan						
Delta Dental	☐ $0.00	☐ $0.00	☐ $0.00	☐ $0.00	☐ $0.00	☐
Vision Plan (Choose One)						
VBA	☐ $4.85	☐ $8.20	☐ $11.40	☐ $8.20	☐ $11.40	☐
Davis Vision	☐ $0.00	☐ $0.00	☐ $0.00	☐ $0.00	☐ $0.00	

Dependent Information

	Name (Last/First/MI)	Gender	Date of Birth	Social Security Number	Medical	Dental	Vision
Spouse		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Dependent		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Dependent		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Dependent		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Dependent		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive

Please check next page to ensure this form is completed in its entirety.

Spending Accounts Options

	Per Pay Contribution	Annual Contribution
Flexible Spending Account (FSA)	**$**	**$** Up to $3,050
Dependent Care Account (DCA)	**$**	**$** Up to $5,000

Employee Signature

Please note that all deductions will be taken on a pre-tax basis unless otherwise instructed. I understand that I cannot change or revoke my election as of any date prior to the next open enrollment period unless I notify my Human Resources office within 30 days of a qualified change in status. The information provided above is true and correct to the best of my knowledge and I accept the provisions that I have read and understood.

Employee Signature _____ Date _____

Creative Benefits, Inc.
strategies to insure your success

Ellis Preserve Office | 3809 West Chester Pike, Suite 190 | Newtown Square, PA 19073
Kingston Office | 31 North Gates Avenue | Kingston, PA 18704

If you have any questions about completing this form, please call Creative Benefits, Inc.'s ESR team or your HR Department.
ESR Team: 1-844-231-8414 | esr@creativebenefitsinc.com

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