The Catholic Health Benefits of Caring (BOC) – Benefits Decision Form

You must submit this completed/signed Form and supporting documentation (i.e. marriage certificate; divorce decree) within 31 days of the Qualifying Status Change (QSC)

Instructions: IMPORTANT: Please review all options listed below prior to completing this form. The completion of the Qualifying Status Change (QSC), and Employee Information section is required for all actions excluding "Update my beneficiary designation".

I Want To:	Action Required:
Add or drop a dependent	Complete the chart below. If you have no other changes (i.e. you are just adding a newborn to your existing coverage) you DO NOT need to fill out pages 2-3. **Sign & date page 3.**
Change my Plan options (i.e. Medical EPO to PPO) or newly enrolling in; or waiving coverage; or changing your Flexible Spending Acct. contribution.	Complete pages 2-3 and Sign & date page 3.
Review my current elections	Visit the Catholic Health intranet and click on System Departments > MyHR. Under MyBenefits, click on View Current Benefits
Review benefits offered	Visit the Benefits Portal at www.benefitsgo.com/chsli
Review Employee Contribution Rate Sheet	Reach out to MyHR at 516-705-6947 or MyHR@chsli.org to request a Rate Sheet
Submit completed form	Send to the HR Service Center via email at MyHR@chsli.org
Update my beneficiary designation	Life Insurance: On the MyHR page of the Catholic Health Intranet, under MyBenefits, click on View/Update Beneficiaries. 403(b) Plan: For Fidelity, update at www.NetBenefits.com/AtWork. For other legacy vendors, contact the vendor directly.

Qualified Status Change (QSC) as of: _____ for: _____
(date) **(reason (i.e. marriage; divorce; birth/adoption of child; loss/gain of coverage))**

Employee Information:

Name: _____Organization/Location: _____ Emp. ID # or Last 4 of SSN: _____

Preferred Phone Number: _____ E-mail Address: _____

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 (select all that apply)
1.	❑/❑					❑ ❑	❑ ❑ ❑
2.	❑/❑					❑ ❑	❑ ❑ ❑
3.	❑/❑					❑ ❑	❑ ❑ ❑
4.	❑/❑					❑ ❑	❑ ❑ ❑

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

❑ I wish to elect dental coverage.

- ❑ **Core:** ❑ Individual ❑ Family
- ❑ **Buy-Up:** ❑ Individual ❑ Family
- ❑ **DHMO[1]:** ❑ Individual ❑ Family

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

[1]Note: If you elect the DHMO plan, you must call Cigna or log into their website, www.cigna.com, and choose a dentist for each person enrolled.

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

❑ I wish to elect medical coverage.

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

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

Davis Vision by MetLife Enhanced Vision Coverage:
(dependent children are eligible for coverage until the end of the year in which they turn **26**)

❑ I wish to elect Davis Vision by MetLife Enhanced Vision coverage.

- ❑ Individual ❑ Individual + 1 ❑ Family

❑ I **do not** wish to elect Davis Vision by MetLife Enhanced Vision coverage.

Flexible Spending Account (FSA):

You may newly enroll in an FSA due to your QSC. If you are currently enrolled, you may also increase your annual contribution (within the maximums), decrease your annual contribution (cannot be less than what you've contributed year-to-date), or stop contributing towards the Healthcare and/or Childcare Pre-Tax FSA.

Health Care FSA: **New Enrollment _____ Change_____ Drop _____**

Health Care FSA allows you to pay for medical, dental and prescription drugs expenses for you and your dependents 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 $3,200)

Childcare Pre-Tax Savings Flexible Spending Account: **New Enrollment _____ Change_____ Drop _____**

The Childcare Pre-Tax Savings 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 Childcare FSA: $_____

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

Long Term Disability (LTD) Insurance Coverage:

❑ I wish to elect LTD Insurance coverage.

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

Supplemental Employee 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.

Dependent Life Insurance for Spouse:

❑ I wish to elect Dependent Life Insurance for my spouse. (insured for $5,000)

Spouse Name: _____

❑ 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)[2]. (insured for $4,000)

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

Supplemental Short Term Disability (STD) Insurance Coverage: Provides additional income replacement, beyond the NYS Disability Plan, in the event you are unable to work due to a non-work related illness or injury.

❑ I wish to elect Short Term Disability Insurance coverage.

❑ $100 ❑ $200

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

Please note: If you enroll in Supplemental Employee Life Insurance and/or Dependent Life Insurance for Spouse, Proof of good health may be required.

If both you and your spouse are benefit-eligible employees of Catholic Health (CH), you may not elect Spouse Life Insurance for one another. Children of two benefit-eligible CH employees may only be covered under Child Life Insurance by one parent.

[2] Unmarried dependent children are eligible until the end of the year in which they turn age 26.

Please Note: The Catholic Health Plan, including the Health Care FSA does not cover expenses for procedures or items that violate the ethical directives of the Roman Catholic Church.

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: _____

Please return ALL three pages to MyHR@CHSLI.org
Questions? Call MyHR at 516-705-MyHR (6947)