Catholic Diocese of Jackson Enrollment Form

Enrollment Period Lasts from November 16th to December 4th **Plan Year: 2021 (1/1/2021 - 06/30/2021)**

Employee Profile Data Please make any necessary corrections on this form.

Employee's Name		Gender		Soc. Sec. #		Date of Hire	
Address Line 1				Date of Birth		Eligible Date	
Address Line 2				Home Phone #		Dept. No.	
City	State Zip			Full/Part-Time			

Your Available Flexible Spending Accounts

Please fill in indicator circles next to each coverage in which you would like to enroll.

Health Care Flexible Spending Account ☐ WAIVE

If you elect this coverage, then a pro rata portion of your annual election will be deducted from each remaining pay periods in the plan year 2021.

◯ Elect coverage - Write in the amount of your Plan Year Election = $_____ The maximum election for 1/1/2021- 06/30/2021 is $1,375.00

Dependent Care Flexible Spending Account ☐ WAIVE

If you elect this coverage, then a pro rata portion of your annual election will be deducted from each remaining pay periods in the plan year 2021.

◯ Elect coverage - Write in the amount of your Plan Year Election = $_____ The maximum election for 1/1/2021 - 06/30/2021 is $2,500.00 *

Dependent Listing

Dependents Full Name (last, first, mi.)	Relationship (i.e., Spouse, Child)	Date of Birth (mm/dd/yyyy)	Soc. Sec. #	Gender (M/F)	Full-Time Student (Yes/No)	Handi-capped (Yes/No)	Remove Date
List Additional Dependents Below (Attach a sheet of paper to list additional dependents, if more space is needed)							

Dependents Separate Legal Home Addresses

Do any of the dependents listed above live at a legal home address different from employee's home address? ◯ Yes ◯ No If yes, provide address in notes below

Your Available Health Plans - Medical, Dental & Vision - Please make an election only if you want to change your current coverage

Medical Plans - Select a coverage level

◯ **Reta Trust Anthem Base Plan:** Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐

◯ **Reta Trust Anthem Buy-up Plan:** Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐

◯ **Waive Medial Coverage**

Dental - Select a coverage level

◯ **Reta Trust Delta Dental Plan:** Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐

◯ **Waive Dental Coverage**

Vision - Select a coverage level

◯ **Reta Trust VSP Vision Plan:** Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐

◯ **Waive Vision Coverage**

Notes:

Submit your enrollment form by Dec. 4, 2020 via email to renee.carpenter@jacksondiocese.org or via fax to (601) 960-8464

Authorization

I hereby elect the amounts I have recorded on this form to be reduced from my gross paycheck. I recognize that my contributions through payroll reduction are completely voluntary and in compliance with State Law. I understand that I cannot change my elections until the next plan year unless I experience a qualified status change event as described in the informational materials, at which time I must notify my employer within 30 days, if I wish to change my elections. Furthermore, in the event I separate from service with my employer, I understand my employer will withhold a portion of wages from my final paycheck(s), in an amount equal to the withholding assessed each pay period, in accordance with my election(s) described in this salary reduction agreement. By selecting a Health Care Flexible Spending Account, I understand that any amounts not claimed from this account during the plan year will be forfeited. By selecting a Dependent/Elder Care Flexible Spending Account, I certify that my dependent day care expenses do not exceed the lower of my or my spouse's income. Furthermore, I understand that any amounts not claimed from this account during the plan year will be forfeited.

Employee's Signature: _____ **Date:** _____