DIOCESE of COVINGTON

Diocese Enrollment 2023-2024

Form is due within 30 days of hire date

Questions:
513-616-6417
Karenbottorff@gmail.com

E-mail Forms to DoCOpenEnrollment@gmail.com

EMPLOYEE INFORMATION:

NAME (LAST, FIRST, M.I.)		SOCIAL SECURITY #	SCHOOL/CHURCH
HOME ADDRESS	APT #	DATE OF HIRE	DATE OF BIRTH / AGE
CITY	STATE ZIP CODE	CELL PHONE	WORK PHONE
E-MAIL ADDRESS		JOB TITLE / POSITION	PAID DURING THE SUMMER Yes ☐ No ☐

DEPENDENT INFORMATION: Dependents to be included for Insurance coverage only, *not* FSA or DCAP

NAME (LAST, FIRST, M.I)	D.O.B.	SOCIAL SECURITY #	SEX	RELATIONSHIP

S125 PLAN ELECTIONS (*Must be made each Plan Year*) Deduction Schedule-18 pays: 9/15/2023 - 5/31/2024

*** New Hire Eligibility- If hire date is on or after September 1st, 2023, eligibility for FSA/DCAP is September 1st, 2024**

Flexible Sending Account (FSA) & LFSA
Out-pocket- medical, dental, vision expenses
Contribute $100 to $3050
Minimum is $100/plan year
Annual Election ☐

Dependent Daycare (DCAP)
Child and/or Adult Daycare expenses
If married filing jointly/single - Contribute up to $5000
If married filing separately - Contribute up to $2500
Annual Election ☐

INSURANCE PLAN ELECTIONS - Deduction Schedule: 24 Pays: 9/15-8/31

*** New Hire Eligibility- 1st day of month following 30 days of employment.**

Delta Dental of Kentucky — **PPO**

Employee Only	$13.16 / pay ☐
Employee + Spouse	$26.32 / pay ☐
Employee + Child(ren)	$29.03 / pay ☐
Family	$54.72 / pay ☐

Legal Shield
Individual - $10.48 / pay ☐ Family - $10.49 / pay ☐

Identify Theft
Indiviudal - $ 4.23 / pay ☐ Family - $ 7.98 / pay ☐

Both Plans
Individual - $14.70 / pay ☐ Family - $16.95 / pay ☐

UNUM Group Term Life Insurance and AD&D

	Benefit Amount
Employee Amount ($10,000-$500,000)	
Spouse Amount ($5,000-$150,000)	
Child Amount ($2,000-$10,000)	

Maximum Guaranteed Issue Amount is 5X Salary
Current Salary ☐

Transamerica Universal Life Insurance with Cash Values
(Separate Enrollment form will be sent)
Check Box

Employee Only - $8.66 / pay	☐
Spouse - $8.66 / pay	☐

Unum Long-Term Disability ☐
Current Salary ☐

BENEFICIARIES (For Life Insurance Only)

NAME (LAST, First, M.I.)	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH

EMPLOYEE AUTHORIZATION/SIGNATURE: **Date:**

I hereby authorize my employer to deduct from my compensation the required contributions for the benefits I have elected above.
I received and read all authorizations provided by each plan elected and agree to comply with such terms and conditions