Diocese Enrollment 2025-2026

Email forms to Benefits@covdio.org

Questions:
Karenbottorff@gmail.com
It is the employee's responsibility to retain a digital copy of this form including original date and time stamp

NEW HIRE ENROLLMENT (within 30 days of hire date) ☐ OPEN ENROLLMENT (May 1 - May 31st) ☐ STATUS CHANGE (within 30 days of event) ☐

SECTION 1: 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
EMAIL ADDRESS	JOB TITLE / POSITION	PAID DURING THE SUMMER YES ◯ NO ◯

SECTION 2: S125 PLAN ELECTIONS (Must be made each Plan Year) Deduction Schedule - 18 Pays: 9/15/2025 - 5/31/2026 *New Hire Eligibility - If hire date is on or after September 1st, 2025, eligibility for FSA/DCAP is September 1, 2026		
Flexible Spending Account or Limited FSA (Out of pocket medical, dental, vision expenses)	**Contribute $500 to $3300**	**Annual Election:** ☐
Dependent Daycare (DCAP) (Child and Adult Daycare expenses)	Married filing jointly /single: **Contribute $500 to $5000** Married filling separately: **Contribute $500 to $2500**	**Annual Election:** ☐

SECTION 3: DELTA DENTAL AND LEGAL SHIELD / INDENTITY THEFT Deduction Schedule - 24 pays				
Delta Dental of Kentucky (PPO)	Single ($13.16 / pay) ◯	Employee and Spouse (26.32 / pay) ◯	Employee + Child(ren) (29.03 / pay) ◯	Family (54.72 / pay) ◯

Legal Shield & Identity Theft			
Legal Shield & Identity Theft	Legal Shield Only	Individual ($10.48 / pay) ☐	Family ($10.48 / pay) ☐
	Identity Theft Only	Individual ($4.23 / pay) ☐	Family ($7.98 / pay) ☐
	Both Plans	Individual ($14.70 / pay) ☐	Family ($16.95 / pay) ☐

NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY #	PHONE #	D.O.B. (MM/DD/YY)	SEX (M/F)	STATUS CHANGE	
SPOUSE					Add	
					Delete	
DEPENDENT					Add	
					Delete	
DEPENDENT					Add	
					Delete	
DEPENDENT					Add	
					Delete	

FOR STATUS CHANGES ONLY:	QUALIFYING EVENT:	EFFECTIVE DATE: (MM/DD/YY)

SECTION 4: INSURANCE PLAN ELECTIONS: Deduction Schedule - 24 pays	
Transamerica Universal Life Insurance with Cash Values	Employee Only ($8.66 / pay) YES ☐ NO ☐ Spouse ($8.66 / pay) YES ☐ NO ☐ **Enrollment form will be required and sent separately**
UNUM Group Term Life Insurance and AD&D	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 Annual Salary** ☐
UNUM Long-Term Disability	**Elgibility - Full-Time Employees Only** **YES** ◯ **NO** ◯ **Current Annual Salary** ☐

BENEFICIARIES (For Life Insurance Only)

NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY #	PHONE #	D.O.B. (MM/DD/YY)	RELATIONSHIP

EMPLOYEE SIGNATURE: **DATE:**

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