



Diocese Enrollment 2026-2027

Email forms to Benefits@covdio.org

Email questions to Liz Champ: Benefits@covdio.org
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 <input type="checkbox"/> NO <input type="checkbox"/>	

SECTION 2: S125 PLAN ELECTIONS (Must be made each Plan Year) Deduction Schedule - 18 Pays: 9/15/2026 - 5/31/2027		
*New Hire Eligibility - If hire date is on or after September 1st, 2026, eligibility for FSA/DCAP is September 1, 2027		
Flexible Spending Account/ Limited FSA (Out of pocket medical, dental, vision expenses)	Contribute \$700 to \$3400 ** Rollover Provision Eliminated in 2026/2027	Annual Election: <input type="text"/>
Dependent Daycare (DCAP) (Child and Adult Daycare expenses)	Married filing jointly /single: Contribute \$700 to \$7500 Married filing separately: Contribute \$700 to \$3750	Annual Election: <input type="text"/>

SECTION 3: DELTA DENTAL AND LEGAL SHIELD / INDENTITY THEFT Deduction Schedule - 24 pays					
Delta Dental of Kentucky (PPO)	Single (\$13.16 / pay) <input type="checkbox"/>	Employee and Spouse (26.32 / pay) <input type="checkbox"/>	Employee + Child(ren) (29.03 / pay) <input type="checkbox"/>	Family (54.72 / pay) <input type="checkbox"/>	
Legal Shield & Identity Theft	Legal Shield Only	Individual (\$10.48 / pay) <input type="checkbox"/>	Family (\$10.48 / pay) <input type="checkbox"/>		
	Identity Theft Only	Individual (\$4.23 / pay) <input type="checkbox"/>	Family (\$7.98 / pay) <input type="checkbox"/>		
	Both Plans	Individual (\$14.70 / pay) <input type="checkbox"/>	Family (\$16.95 / pay) <input type="checkbox"/>		
NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY #	PHONE #	D.O.B. (MM/DD/YY)	SEX (M/F)	STATUS CHANGE
SPOUSE					Add <input type="checkbox"/> Delete <input type="checkbox"/>
DEPENDENT					Add <input type="checkbox"/> Delete <input type="checkbox"/>
DEPENDENT					Add <input type="checkbox"/> Delete <input type="checkbox"/>
DEPENDENT					Add <input type="checkbox"/> Delete <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>	Spouse (\$8.66 / pay) YES <input type="checkbox"/> NO <input type="checkbox"/>	Enrollment form will be required and sent separately
UNUM Group Term Life Insurance and AD&D	Employee Amount (\$10,000 - \$500,000) <input type="text"/>	Spouse Amount (\$5,000 - \$150,000) <input type="text"/>	Child Amount (\$2,000 - \$10,000) <input type="text"/>
	Maximum Guaranteed Issue Amount is 5X Salary		Current Annual Salary <input type="text"/>
UNUM Long-Term Disability	Eligibility - Full-Time Employees Only YES <input type="checkbox"/> NO <input type="checkbox"/>		Current Annual Salary <input type="text"/>

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

EMPLOYEE SIGNATURE:	DATE:
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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.
**The Rollover Provision for the FSA beginning plan year 2026/2027 will be eliminated. FSA funds must be spent by August 31, 2027.