The Episcopal Diocese of San Diego

EDSD
COURAGEOUS LOVE

Employee Enrollment & Change Form 2027

Please e-mail this form to: acazarez@edsd.org

1 Information About the Employee

☐ New Employee (Complete section 1 through 9)

☐ Termination (Complete section 1, 2, 6, 7, 8 – employer signature)*

☐ Other Status (Specify) _____
Address change, name change, new dependent, deceased, marriage, divorced, etc. (Complete all necessary sections)

☐ Salary Change from _____ to _____ per year
(Complete sections 1, 2, and 7 (employee & employer signature))

☐ Change in Hours from _____ to _____ per year
(Complete all necessary sections)

_____
Title First Name MI Last name

_____ _____
Hire/Term Date Effective Date of Coverage

☐ Married ☐ Single ☐ Registered Dometic Partnership

Date of Marriage: _____

☐ Male ☐ Female

☐ Clergy ☐ Lay

Residence

_____
Street

_____
City State Zip

_____
Home Phone Email

Mailing Address

_____
Street

_____
City State Zip

2 Billing Information

_____ _____
Name of Organization Phone Email List Bill ID

_____ _____
Street City State Zip

3 Disability Life Unemployment

☐ Short-term Disability
☐ Long-term Disability

☐ Life + AD&D

Generally these are governed for lay people by parish policy. Check with your congregational policy. The Clergy Pension covers these items for clergy.

Does the congregation participate in the State Unemployment Plan? ☐ Yes ☐ No

Employee's annual salary _____

4 Active Medical Coverage

Regular Plans

☐ Kaiser EPO 80 Plan
☐ Anthem CDHP – 15/HSA
☐ Anthem CDHP – 20/HSA
☐ Anthem BCBS BlueCard PPO 80
☐ EAP Only

Medicare Secondary Payer (additional forms required)

For employees 65 and older enrolled in Medicare and actively working (Only available to employers with no more than 19 employees)

☐ Anthem BCBS BlueCard MSP PPO 80

Tier

☐ Single
☐ Employee + Spouse
☐ Employee + Child (ren)
☐ Family

☐ **Medical coverage declined**
(note: if working 1500+ hours/ year, must also submit waiver)

Additional HSA from employee (per paycheck): _____
CDHP participants may contribute additional funds to their HSA.

For Administrators:

Birthdate/s and Social Security Number/s for employee and employee dependent/s must be entered in MY ADMIN PORTAL (MAP) first before sending in this form. Please contact Anabel Cazarez if you need assistance with entering information in MAP.

5

Active Dental Coverage ☐ **Add Coverage** ☐ **Terminate Coverage**

- ☐ Basic PPO Dental Plan
- ☐ Comprehensive PPO Dental Plan
- ☐ Premium Dental PPO Plan
- ☐ **Dental coverage declined**

Tier

- ☐ Single
- ☐ Employee + Spouse
- ☐ Employee + Child (ren)
- ☐ Family

6

Information About Your Dependents ☐ Add Coverage ☐ Terminate Coverage

Coverage	Full Name	Relationship	Gender
☐ Medical ☐ Dental			☐ Male ☐ Female
☐ Medical ☐ Dental			☐ Male ☐ Female
☐ Medical ☐ Dental			☐ Male ☐ Female

7

Signature — Employee, Employer and Sponsoring Diocese or Organization

The employee, employer and an officer of the sponsoring diocese or organization must sign this form. By signing, the employer certifies the employee is eligible for all coverages applied for, and, to the best of the employer's knowledge, all information provided is correct.

Employee Signature ** Date Employer Signature Date

Street City State Zip Phone Email

*Employee's signature is not required for termination of coverage due to termination of employment.
Employee's signature is required for employee's voluntary termination of employee and/ or employee dependent(s) coverage.
Please complete section 6 for termination of dependent(s) coverage.

**Include Power of Attorney documentation if applicable.

8

Retirement ☐ Add coverage ☐ Change coverage ☐ Terminate coverage

- ☐ Clergy Pension
- ☐ Clergy RSVP Contribution % _____
- ☐ Lay 403b -- Traditional Contribution % _____
- ☐ Lay 403b -- Roth Contribution % _____

9

Please return your enrollment within 30 days from your date of hire or date of eligibility.
*Note that employee coverage is effective the first of the month following your date of hire or date of eligibility. (If your date of hire or eligibility is the first working day of the month and the first calendar day of the month (e.g., Monday, June 1) coverage begins on the first of that month)

Keep the original documents in a secure personnel file on site.

For questions about the form, please contact: Anabel Cazarez acazarez@edsd.org
Office Phone 619-481-5466