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**Information About the Employee**

☐ New Employee (Complete section 1 through 8)

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

☐ Other Status (Note below) \_\_\_\_\_

Status details (Address change, new dependent, deceased, marriage, divorce, etc. (Complete all necessary sections)

☐ Salary Change \$ \_\_\_\_\_

(Complete sections 1, 2 and 7 (employee & employer signature)

**Residence**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Email \_\_\_\_\_

**Mailing Address**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

☐ Male ☐ Clergy ☐ Married ☐ Single

☐ Female ☐ Lay Date of Marriage: \_\_\_\_\_

2

**Billing Information**

Name of Organization \_\_\_\_\_

Street \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3

**Disability for lay employees**

☐ Short-term Disability

☐ Long-term Disability

**Life**

☐ Life + AD&D

**Unemployment**

Does the employee participate in the Diocesan Unemployment Plan? ☐ Yes ☐ No

Employee's annual salary \_\_\_\_\_

4

**Active Medical Coverage**

**Regular Plans**

☐ Anthem BCBS PPO 100

☐ Anthem BCBS PPO 90

☐ Anthem BCBS PPO 80

☐ Anthem BCBS PPO 70

☐ Anthem CDHP – 40/HSA

☐ Anthem CDHP – 20/HSA

☐ Anthem CDHP – 15/HSA

☐ Kaiser EPO High

☐ Kaiser EPO 90

☐ Kaiser EPO 80

☐ Kaiser CDHP – 20/HSA

☐ Employee Assistance only (EAP)

**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 100

☐ Anthem BCBS BlueCard MSP PPO 90

☐ Anthem BCBS BlueCard MSP PPO 80

☐ Anthem BCBS BlueCard MSP PPO 70

**Tier**

☐ Single

☐ Employee + Spouse

☐ Employee + Child (ren)

☐ Family

☐ Medical Coverage Declined

**For Administrators:**

Birthdate(s), Social Security Number(s) and all basic information must be entered in MY ADMIN PORTAL (MAP) first for employee and employee dependent/s before you e-mail this form to Canon Anilin Collado Please contact Anilin Collado if you need assistance with entering the employee information in MAP.

**5****Active Dental Coverage**☐ **Add Coverage**☐ **Terminate Coverage**☐ Preventive Dental Plan☐ Basic Dental Plan☐ Dental & Ortho 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                          |
|----------------------------------|-----------|--------------|---------------------------------|
| <input type="checkbox"/> Medical |           |              | <input type="checkbox"/> Male   |
| <input type="checkbox"/> Dental  |           |              | <input type="checkbox"/> Female |
| <input type="checkbox"/> Medical |           |              | <input type="checkbox"/> Male   |
| <input type="checkbox"/> Dental  |           |              | <input type="checkbox"/> Female |
| <input type="checkbox"/> Medical |           |              | <input type="checkbox"/> Male   |
| <input type="checkbox"/> Dental  |           |              | <input type="checkbox"/> 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 |  |
| The Episcopal Diocese of Los Angeles       |             |       |       |                       |                         |      |  |
| Name of Sponsoring Diocese or Organization |             |       |       | Officer's Signature   |                         | Date |  |
| 840 Echo Park Avenue                       | Los Angeles | CA    | 90026 | 213-482-2040, ext 250 | acaollado@ladiocese.org |      |  |
| 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.

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For questions about the form, please contact Canon Anilin Collado at the following information:

E-mail: [acollado@ladiocese.org](mailto:acollado@ladiocese.org)

Office number: 213-482-2040, ext. 250

Mobile number for calls or sending a text message: 213-999-3179.

Please e-mail this form to: [acollado@ladiocese.org](mailto:acollado@ladiocese.org)