

Human Resource Use	TYPE OF ENROLLMENT: <input type="checkbox"/> New Hire <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Late Entrant	Location/Division Code	LOCATION NAME:			DATE OF HIRE:
<input type="checkbox"/> Is this Enrollment Due to a Qualifying Life Event (Event examples: Marriage, Birth, Adoption, Divorce) Event: _____		DATE OF LIFE EVENT:	EMPLOYEE PHONE # <input type="checkbox"/> Cell <input type="checkbox"/> Home	EMPLOYEE EMAIL ADDRESS:		
EMPLOYEE NAME:	EMPLOYEE DATE OF BIRTH:	EMPLOYEE SOCIAL SECURITY #:	MARITAL STATUS:	DATE OF MARRIAGE: (IF APPLICABLE)	EMPLOYEE GENDER:	
ADDRESS:	SS#	CITY:	STATE:	ZIP:		
SPOUSE NAME	SS#	SPOUSE DATE OF BIRTH	SPOUSE GENDER			
CHILD NAME	SS#	CHILD DATE OF BIRTH	CHILD GENDER	FULL-TIME STUDENT? (Y OR N)		
CHILD NAME	SS#	CHILD DATE OF BIRTH	CHILD GENDER	FULL-TIME STUDENT? (Y OR N)		
CHILD NAME	SS#	CHILD DATE OF BIRTH	CHILD GENDER	FULL-TIME STUDENT? (Y OR N)		
CHILD NAME	SS#	CHILD DATE OF BIRTH	CHILD GENDER	FULL-TIME STUDENT? (Y OR N)		
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CHILD NAME	SS#	CHILD DATE OF BIRTH	CHILD GENDER	FULL-TIME STUDENT? (Y OR N)		
CHILD NAME	SS#	CHILD DATE OF BIRTH	CHILD GENDER	FULL-TIME STUDENT? (Y OR N)		
<b>BASIC LIFE/AD&amp;D PLAN with Guardian Policy 538250</b>						
<b>BASIC LIFE/AD&amp;D PLAN:</b> Your employer provides you with the following life insurance coverage at no cost to you. Your employer provides Basic Term Life and AD&D Coverage in the amount of 2.5 times your base annual earnings, up to a maximum of \$200,000.						
<b>DISABILITY COVERAGE: Guardian Policy 538250</b>						
<b>DISABILITY COVERAGE:</b> Your employer provides you with the following disability insurance at no cost to you: <input checked="" type="checkbox"/> Short Term Disability (STD) Coverage: 60% of your salary to a maximum of \$1,000 per week <input checked="" type="checkbox"/> Long Term Disability (LTD) Coverage: 60% of your salary to a maximum of \$4,000 per month						
<b>EMPLOYEE VOLUNTARY LIFE and VOLUNTARY AD&amp;D with Guardian Policy 538205</b>						
<p><b>LIFE:</b> You may elect additional Life Insurance for yourself and your dependents.          You may elect coverage for yourself in one of the following amounts:  <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000</p> <p>You must be covered for Voluntary Life coverage in order to purchase coverage for your spouse and/or child(ren).          • You may elect coverage for your spouse in the amount of \$25,000.          • You may elect coverage for your child(ren) in the amount of \$10,000.</p> <p>Monthly rates and premiums are based on your age on January 1st each year.          Your child(ren) are covered for voluntary life to their 26<sup>th</sup> birthday.</p> <p><b>During your initial eligibility period (new hires),</b> you may elect up to the Guarantee Issue Limit of \$150,000 without completing EOI (Evidence of Insurability). If you decline coverage when it is initially offered to you, you will be required to complete EOI and you may be declined for coverage.</p> <p><b>Qualifying Events:</b> you may elect either Spouse or Child(ren) coverage without completing EOI on the occurrence of marriage, birth or adoption.</p>				<p><input type="checkbox"/> No change to current election</p> <p><input type="checkbox"/> I want to elect <b>Employee Coverage</b> in the amount of \$ _____</p> <p><input type="checkbox"/> I want to elect <b>Spouse Coverage</b> in the amount of \$25,000</p> <p><input type="checkbox"/> I want to elect <b>Child Coverage</b> in the amount of \$10,000</p> <p><input type="checkbox"/> I decline coverage (EOI will be required in the future)</p> <p><i>Your request will not be effective until you receive carrier approval.</i></p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>New Hires:</b> You are eligible to enroll within 30 days of your Date of Hire.</p> <p><b>Existing Employees:</b> You will be eligible to enroll or make changes at the next scheduled Open Enrollment for Voluntary Life, held during May 2022 and effective on July 1, 2022.</p> </div>		

**Employee Authorization Signature Required on Page 2 of this Enrollment Form.**

### DENTAL with Guardian Policy 538205

**PPO DENTAL:** You may elect coverage for yourself and your dependents.

Your dental plan uses Guardian's DentalGuard Preferred PPO Network.

Find a Provider Near You at [www.GuardianAnytime.com](http://www.GuardianAnytime.com) and click on 'Find a Provider'.

#### Low Plan:

\$50 Deductible, \$1,250 Annual Maximum

Preventive: Covered at 100%

Basic : Covered at 80%

Major: Not Covered

Ortho: Not Covered

#### High Plan:

\$50 Deductible, \$1,250 Annual Maximum

Preventive: Covered at 100%

Basic : Covered at 80%

Major: Covered at 50% after 6 months

Ortho: Covered at 50% after 12 months

**No change** to current election

I want to **elect** Dental coverage:

Low Plan       High Plan

I want to elect Employee Only Dental coverage.

I want to elect Dental coverage for Employee + 1 Dependent

I want to elect Dental coverage for Employee + 2 or More Dependents

I **decline** Dental coverage for this Plan Year.

### VISION with Guardian Policy 538205

**VISION:** You may elect coverage for yourself and your dependents.

Your vision plan uses the VSP Signature Network.

Find a Provider Near You at [www.GuardianAnytime.com](http://www.GuardianAnytime.com) and click on 'Find a Provider'.

No change to current election

I want to elect Employee Only Vision coverage.

I want to elect Employee + Spouse Vision coverage

I want to elect Employee + Child(ren) Vision coverage

I want to elect Employee + Family Vision coverage

I decline Vision coverage for this Plan Year.

### ACCIDENT with Guardian Policy 538205

**ACCIDENT:** You may elect coverage for yourself and your dependents.

I want to elect Employee Only Accident coverage.

I want to elect Employee + Spouse Accident coverage

I want to elect Employee + Child(ren) Accident coverage

I want to elect Employee + Family Accident coverage

I decline Accident coverage for this plan Year

### CRITICAL ILLNESS with Guardian Policy 538205

**CRITICAL ILLNESS:** You may elect coverage for yourself and your dependents.

#### Employee Insurance Amount:

\$10,000

\$20,000

I decline Critical Illness coverage for this Plan Year

Monthly rates and premiums are based on your age on January 1st each year.

Your child(ren) are covered until their 26<sup>th</sup> birthday.

If you decline coverage when it is initially offered to you, you will be required to complete EOI and you may be declined for coverage.

**Spouse Insurance Amount:** May not exceed 50% of the employee's amount

\$5,000

\$10,000 (*Amount available only if Employee elects \$20,000 of Critical Illness*)

I decline Critical Illness coverage for this Plan Year

**Dependent Child(ren) Amount:** May not exceed 25% of the employee's amount

I want to elect Child(ren) Critical Illness coverage at 25% of my benefit election

I decline Child(ren) Critical Illness for this Plan Year

**EMPLOYEE AUTHORIZATION**

I verify that this enrollment form reflects my benefit elections under this plan. I have read the enrollment materials provided to me. I authorize my employer to deduct from my wages or salary any required premium contribution on a post-tax basis (Voluntary Life/Disability) as stipulated by this plan and my elections. I understand that my election will be effective through the end of the Plan Year and that I may not change my elections unless I experience a qualified change in status (as noted in the enrollment materials). If I experience a change in status, I must notify Human Resources and request to change my election within 30 days of the event, or I must wait until the next open enrollment period to change my election.

Life/Disability Disclaimer: I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex. I further understand that if I am not in active service on the date my coverage would otherwise take effect, I will be covered on the date I return to active service.

This disability plan includes a Pre-Existing Condition Limitation. Please refer to your certificate of coverage booklet for complete details regarding these provisions and all other provisions.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet

If coverage is waived and you later decide to enroll, you may have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

Truth & Knowledge Disclaimer: I attest that the information provided above is true and correct to the best of my knowledge.

Fraud Statement: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

**Required Signature/Date:**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employee Authorization Signature Required on Page 2 of this Enrollment Form.**



# BENEFICIARY DESIGNATION FORM

Employer Name: ARCHDIOCESE OF NEW ORLEANS  
Guardian Group Plan ID #: 538205 (Voluntary Life)  
538250 (Basic Life)

EMPLOYEE NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	MARITAL STATUS:	EMPLOYEE PHONE # <input type="checkbox"/> Cell <input type="checkbox"/> Home
ADDRESS:			CITY:	STATE: ZIP:

**Primary and Contingent Beneficiaries:** Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

BENEFICIARY INFORMATION: Basic Life and Basic AD&D					
I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:					
Name	Address & Phone Number	Gender	Relationship (if spouse list date of marriage)	Date of Birth	% (Total Must Equal 100%)
<b>Primary Beneficiary(ies)</b>					
<b>Contingent Beneficiary(ies)</b>					

BENEFICIARY INFORMATION: Voluntary Life and Voluntary AD&D					
I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:					
Name	Address & Phone Number	Gender	Relationship (if spouse list date of marriage)	Date of Birth	% (Total Must Equal 100%)
<b>Primary Beneficiary(ies)</b>					
<b>Contingent Beneficiary(ies)</b>					

Please Note: Employee is automatically the beneficiary for Spouse and Child Voluntary Life coverage.

Employee Signature	
Employee Signature: _____	Date: _____

### Guidelines for Designation of Beneficiaries

**General:** Please be sure to include the beneficiary's full name and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

**Minors:** While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.

**Trust as Beneficiary:** You may designate a trust as beneficiary as follows: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]"

**Life Status Changes:** We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, birth of a child, etc.

**See an Attorney:** The above guidelines are general and not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

### VOLUNTARY LIFE ENROLLMENT

**New Hires:** You are eligible to enroll within 30 days of your Date of Hire.

**Existing Employees:** You will be eligible to enroll or make changes at the next scheduled Open Enrollment for Voluntary Life, held during May 2022 and effective on July1, 2022.