

Diocese of Gary

Benefits Green Form (Additions, Terminations or Changes)

Parish/School Name _____ Branch Code _____

Employee's Name _____
Last Name First Name Middle Initial

Street Address _____ Phone: (____) _____

City _____ State _____ Zip Code _____

Sex ____ Date of Birth ____/____/____ Social Security Number _____
Month Day Year

Position _____ Full-time Yes or No
Circle One

Indicate the number of hours per week, if part-time _____

New Employment with the Diocese of Gary

First Date of Full-time Employment ____/____/____
Month Day Year

PLEASE SEND THIS FORM AS SOON AS POSSIBLE. COVERAGE IS EFFECTIVE FROM THE FIRST DATE OF EMPLOYMENT FOR MEDICAL, LIFE AND PRESCRIPTION COVERAGE.

Note: You must offer any employee scheduled to work 30 hours a week or more the health, life, vision and dental insurance.

If the employee elects to take both health and life insurance, send a medical enrollment form, and a life insurance beneficiary form along with this document. You should also include a payroll deduction form if the employee elects to enroll dependents in the medical insurance plan.

If the employee waives the medical plan, they may elect to take the life insurance only. In this case, send the life insurance beneficiary form and a voluntary waiver form along with this document.

The forms mentioned above are available in a PDF format at www.dcgary.org. Scroll down on the home page to the Office of Benefits and you will see the link to forms.

Remember to inform your new employee to watch for a packet from the Benefits Office which will include information and enrollment materials for the vision and dental insurance plans. They should return the enrollment forms to you to forward to the Benefits Office.

Rehire

First date of employment: _____ / _____ / _____
Month Day Year

Where was this person last employed? _____

Termination of Coverage of Staff Leaving the Diocese of Gary

Last Day Worked : _____ / _____ / _____
Month Day Year

Note: Medical coverage ends on August 31st for any contracted teacher that completed the school term. We will not bill in August for this teacher.

Coverage for clerical and maintenance staff ends on the last day of the month in which their employment ended.

Please Send Timely Notice of Termination . The Benefits Office must offer terminating employees medical conversion insurance, and they only have 31 days from the date their coverage ended to make application. Also, we must offer a timely notice of termination with regard to HIPAA laws in order to eliminate pre-existing condition periods for any new coverage a terminated employee may obtain in the future.

Opting Out of Medical Coverage by an Active Employee

Date: _____ / _____ / _____
Month Day Year

(Please attach a Voluntary Waiver of Coverage Form)

Retirement

Last Day Worked: _____ / _____ / _____
Month Day Year

Please ask the employee to contact the Benefits Coordinator at (219) 769-9292, extension 277 to discuss the details of beginning their retirement payments as soon as possible.

Transfer

What is the new parish or school? _____

Will this person be full-time in the new parish or school? Yes or No
Circle one

Date the transfer is effective: _____ / _____ / _____
Month Day Year

(This should be the first day at the new location)

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Leave of Absence

Date the leave will begin: _____
Month Day Year

Reason for the leave of absence: _____

For example, a personal illness, family illness, or military service

Date the leave is expected to end: _____
Month Day Year

(Please remember to inform the Benefits Office of the date of return)

Return from Leave of Absence

Date this person returned from leave of absence: _____
Month Day Year

Add or Delete a Dependent for Medical Insurance

Attach a Medical Enrollment Form to add a dependent, and attach a Anthem change form to delete a dependent– available at www.dcgary.org

Change of Life Insurance Beneficiary

Attach a Life Insurance Beneficiary Form with the word “CHANGE” printed across the top. The form is available at www.dcgary.org

Report the Death of an Employee or Retiree

Date of the death: _____
Month Day Year

Who will be handling the affairs of the deceased?

Name _____

Relationship to the deceased _____

Street Address _____

City, State, Zip Code _____

Day time phone number: (____) _____

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Remarks Please use this section to inform us of any situation that this form did not address, or to provide any detail that may be necessary.

This form was completed by :

(Signature of secretary completing this form, if applicable)

Date: _____

This addition, termination or change approved by:

(Signature of Pastor, Principal or Director approving)

Date: _____

**Please mail the completed form to:
Benefits Office
Diocese of Gary
9292 Broadway
Merrillville, IN 46410**

Space Below is for Benefits Office Use

Date Received _____ Retirement Record ABRA _____

Estimate _____

Medical & Life ABRA _____ Dental and Vision ABRA _____

A&D _____ FC _____

SP _____

Revised February 2012