

**Diocese of Gary**  
**Authorization for Dental and Vision Payroll Deduction Form**  
**Plan year 2016-2017**

I wish to participate in the Anthem PPO Low or High voluntary dental and/or the Anthem Blue View Vision voluntary vision with the coverage type(s) indicated below:

**Please check one for voluntary dental:**

|                       |                                 |                                     |                                 |
|-----------------------|---------------------------------|-------------------------------------|---------------------------------|
| Anthem PPO Low Plan:  | Single _____<br>\$14.81 monthly | Single + 1 _____<br>\$29.62 monthly | Family _____<br>\$38.51 monthly |
| Anthem PPO High Plan: | Single _____<br>\$22.53 monthly | Single + 1 _____<br>\$44.23 monthly | Family _____<br>\$67.60 monthly |

I choose to waive the voluntary dental insurance: \_\_\_\_\_

*I understand that by waiving coverage I will not be able to enroll in the voluntary dental plan until the 2017/2018 open enrollment period with an effective date of July 1, 2017 unless I have a change of status.*

**Please check one for voluntary vision:**

|                                       |  |  |                                 |
|---------------------------------------|--|--|---------------------------------|
| Employee only _____<br>\$6.83 monthly | Employee + Spouse _____<br>\$13.24 monthly | Employee + Children _____<br>\$13.86 monthly | Family _____<br>\$21.35 monthly |
|---------------------------------------|--|--|---------------------------------|

I choose to waive the voluntary vision insurance: \_\_\_\_\_

*I understand that by waiving coverage I will not be able to enroll in the voluntary vision plan until the 2017/2018 open enrollment period with an effective date of July 1, 2017 unless I have a change of status.*

I authorize a monthly payroll deduction(s) from my salary in the amount(s) indicated above. I understand that the monthly deduction(s) will continue for a minimum of 12 (twelve) months unless I: **(1)** report a change of status to the Benefits Office within 31 days of the change of status date OR **(2)** notify the Benefits Office in writing during the next annual open enrollment period of my wish to drop coverage.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Location (Parish, School or Institution Name)

**Please return to local person in charge of benefits**

**Benefits Office Use Only**

|                 | Dental | Vision |
|-----------------|--------|--------|
| Effective Date  | _____  | _____  |
| Data Entry Date | _____  | _____  |
| ABRA Entry Date | _____  | _____  |