Diocese of Gary
Authorization for Dental and Vision Payroll Deduction Form
Plan year 2019/2020

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 _____ $19.83 monthly	Single + 1 _____ $39.68 monthly	Family _____ $51.58 monthly
Anthem PPO High Plan:	Single _____ $30.18 monthly	Single + 1 _____ $59.25 monthly	Family _____ $90.54 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 2020/2021 open enrollment period with an effective date of July 1, 2020 unless I have a change of status.

Please check one for voluntary vision:

Employee only _____ $6.83 monthly	Employee + Spouse _____ $13.24 monthly	Employee + Children _____ $13.86 monthly	Family _____ $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 2020/2021open enrollment period with an effective date of July 1, 2020 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 Human Resources 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	_____	_____