THE EPISCOPAL DIOCESE OF FORT WORTH

EMPLOYEE BENEFITS ENROLLMENT / CHANGE FORM

PLAN YEAR - September 1, 2021 - August 31, 2022

PLEASE CHECK APPROPRIATE BOX: ☐ Open Enrollment ☐ Initial Enrollment ☐ Add Employee / Dependents ☐ Drop / Refuse Coverage ☐ Information Change

Employee Name (as on your Social Security Card)			Social Security Number	Date of Birth (Month/Day/Year)	Marital Status ☐ Single ☐ Married
Address			Telephone Number		Gender ☐ Male ☐ Female
City	State	Zip Code	Date of Hire	Annual Salary	Average Number of Hours Worked

ELECTIONS - Premiums shown are monthly

Medical - HSA Base Plan	Cigna	☐ Employee Only Cost - $937.90	☐ Employee & Spouse Cost - $2,236.50	☐ Employee & Child(ren) Cost - $1,850.24	☐ Employee & Family Cost - $2,661.72	☐ Waive
Medical - PPO Buy-Up Plan	Cigna	☐ Employee Only Cost - $1,044.25	☐ Employee & Spouse Cost - $2,486.59	☐ Employee & Child(ren) Cost - $2,074.91	☐ Employee & Family Cost - $2,934.32	☐ Waive
IF YOU ARE WAIVING MEDICAL COVERAGE: Do you or your dependents have other insurance?		☐ Yes ☐ No	If "Yes" please provide dependent relationship: Self / Spouse / Child (Circle one or more) Name of Insurance Carrier: Effective Date:			
Dental PPO	Cigna	☐ Employee Only Cost - $43.96	☐ Employee & Spouse Cost - $98.78	☐ Employee & Child(ren) Cost - $106.80	☐ Employee & Family Cost - $154.07	☐ Waive
IF YOU ARE WAIVING DENTAL COVERAGE: Do you or your dependents have other insurance?		☐ Yes ☐ No	If "Yes" please provide dependent relationship: Self / Spouse / Child (Circle one or more) Name of Insurance Carrier: Effective Date:			
Vision	Cigna	☐ Employee Only Cost - $12.63	☐ Employee & Spouse Cost - $19.50	☐ Employee & Child(ren) Cost - $20.26	☐ Employee & Family Cost - $27.89	☐ Waive

Dependent Name (as on their Social Security Card)	Relationship	Social Security Number	Date of Birth	Gender (Circle One)	Disabled (Circle One)
	Spouse / Child (Circle One)			M / F	Yes / No
	Child			M / F	Yes / No
	Child			M / F	Yes / No
	Child			M / F	Yes / No
	Child			M / F	Yes / No
	Child			M / F	Yes / No
	Child			M / F	Yes / No

I understand and agree that the medical, dental and vision benefits are provided through a Section 125 Cafeteria Plan arrangement and that my share of the cost will be deducted from my pay on a pre-tax basis, reducing my taxable income. I realize that my elections will continue in effect through August 31, 2022, and I can change these elections only during the annual open enrollment period or if there has been a qualifying change in my family status, employment or group healthcare coverage. **See page 2 for additional details.**

I understand that the medical plan being offered is designed to meet the "Affordability" and "Minimum Value" requirements of the Affordable Care Act and as a result, if I choose to waive the opportunity to enroll in the medical plan, I may be ineligible to receive a premium tax credit and/or cost-sharing subsidy.

EMPLOYEE SIGNATURE - Required for Enrollment and/or Waiver

X _____ _____

Employee Signature Date

Print Name: _____

ANGLICAN BENEFITS PROGRAM

EMPLOYEE BENEFITS ENROLLMENT / CHANGE FORM

PLAN YEAR - September 1, 2021 - August 31, 2022

PLEASE CHECK APPROPRIATE BOX: ☐ Open Enrollment ☐ Initial Enrollment ☐ Add Employee / Dependents ☐ Drop / Refuse Coverage ☐ Information Change

Employee Name (as on your Social Security Card)	Social Security Number	Date of Birth (Month/Day/Year)	Marital Status ☐ Single ☐ Married
Employment Status ☐ Active ☐ Retired / Employed Full Time? ☐ Yes ☐ No	Are you authorized to work and reside in the US? ☐ Yes ☐ No		Average Number of Hours Worked
Address	Telephone Number		Gender ☐ Male ☐ Female
City / State / Zip Code	Date of Hire	Annual Salary	

ELECTIONS - AMERICAN UNITED LIFE INSURANCE COMPANY

Short-Term Disability Benefit	☐ Elect ☐ Decline	☐ Clergy ☐ Lay Person
Long-Term Disability Benefit	☐ Elect ☐ Decline	☐ Clergy ☐ Lay Person
Group Life / AD&D Benefit (Employee Only)	☐ $150,000 ☐ $100,000 ☐ $75,000 ☐ $50,000 ☐ Decline Group Life / AD&D	☐ Clergy ☐ Lay Person

Participants in the Diocesan 403b Retirement Program will automatically receive a $50,000 Group Life/AD&D benefit, in addition to the amount selected above; as well as automatic enrollment in the Short-Term Disability and the Long-Term Disability benefits.

Voluntary Life / AD&D Benefit	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family ☐ Decline Voluntary Life / AD&D
Voluntary Life / AD&D NEW Election:	Employee: $ Spouse: $ Child(ren): $

If You and Your eligible Dependents enroll when first eligible, You may apply for any amount of life insurance coverage up to the Guarantee Issue Amount of $110,000 on yourself and $25,000 for Your Spouse without furnishing Evidence of Insurability. Any life insurance coverage over the Guarantee Issue Amounts will be subject to Evidence of Insurability. If You enroll when first eligible, You may increase your benefit at the next annual enrollment period by 10% or $10,000, whichever is greater, up to the maximum allowed amount without furnishing Evidence of Insurability. If You and your eligible Dependents do not enroll when first eligible, You can apply for coverage only during a Scheduled Enrollment Period, and will be required to furnish Evidence of Insurability for the entire amount of coverage.

Complete Dependent Information Below if Enrolling Spouse or Child(ren) in Voluntary Life / AD&D Benefit

Dependent Name (as on their Social Security Card)	Relationship	Social Security Number	Date of Birth	Gender (Circle One)
	Spouse / Child (Circle One)			M / F
	Child			M / F
	Child			M / F
	Child			M / F
	Child			M / F
	Child			M / F

The undersigned understands and agrees any insurance coverage or benefit are contingent upon any statements made to AUL as being complete and correct. The undersigned have read, understand, and retained the notices, limitations and exclusions for his/her records.

I authorize my employer to deduct from my wages the amount of premium required for the amount of coverage approved by AUL, including any premium increases due to age bracket or salary changes when applicable. Premium payments greater than the amount of premium owed will not result in additional coverage under AUL's policy.

FRAUD WARNING: Any person, who, with intent to defraud by knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

PLEASE BE SURE TO COMPLETE A GROUP LIFE / AD&D AND VOLUNTARY LIFE / AD&D BENEFICIARY FORM

Employee Signature

X _____ **Date** _____

If you live in a community property state, you will need to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states currently include: AZ, CA, ID, LA, NV, NM, TX, WA and WI.

In Community Property States, Spouse Signature

X _____ **Date**

Parish Authorization

X _____ **Date**

Parish:	Parish Contact:
Address (Mailing):	
City:	State and Zip Code:
Parish Telephone Number:	Diocese/Convocations:
Parish Email Address:	Billing E-mail Address:

DISCLAIMERS

I understand and agree:

• In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description which may require additional limitations and waiting periods.

• I may be required to furnish evidence of health status satisfactory to the carrier.

• If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my dependents in this plan if eligibility for that other coverage is lost (or if the employer stops contributing towards that coverage). However, I must request enrollment within 30 days or any longer period that applies under the plan administrator after the other coverage ends (or after the employer stops contributing toward the other coverage).

• If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents. However, I must request enrollment within 30 days or any longer period that applies under the plan administrator after the marriage, birth, adoption, or placement for adoption.

• If I decline enrollment for myself or for an eligible dependent (including my spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, I may be able to enroll myself and my dependents in this plan if eligibility for that other coverage is lost. However, I must request enrollment within 60 days after coverage ends under Medicaid or the state children's health insurance program.

• The carrier reserves the right to delay medical coverage and/or deny dental, basic life or voluntary life with any future application for coverage.

• If I gain eligibility for a state premium assistance subsidy through a Medicaid plan under Title XIX of the Social Security Act, or the state children's health insurance program (CHIP) under Title XXI of the Social Security Act, I may be able to enroll myself and my dependents in this plan. However, I must request enrollment within
60 days or any longer period that applies under the plan administrator.

• If I decline enrollment for myself or for an eligible dependent (including my spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, I may be able to enroll myself and my dependents in this plan if eligibility for that other coverage is lost. However, I must request enrollment within 60 days after coverage ends under Medicaid or the state children's health insurance program.

Authorization/Acknowledgement: I hereby authorize those providing services to me, or my dependents, to release relevant information or medical records to this plan. I have read, or have had read to me, all information contained in this form and such information is accurate and complete to the best of my knowledge. I understand that if I have made a material false statement, misrepresentation or omission on this form that changes the risk assumed by this plan I may lose coverage under this plan. I also understand that those who provide services to me under this plan are not agents, representative or employees of this plan. I understand that my salary will be reduced in accordance to the plan guidelines if payroll deductions are necessary.

Disclaimer: This Enrollment Form (this "Form") is presented by Frost Insurance Agency, Inc. ("FIA") on behalf of The Episcopal Diocese of Fort Worth and is for illustrative and informational purposes only. This Form does not include all of the details contained in the applicable insurance contracts and plan documents. If there is any discrepancy between this information and the insurance contracts and plan documents, the insurance contracts and plan documents will control. Eligibility for coverages and entitlement to plan benefits, if any, are not determined by Frost Insurance Agency. Please contact the Plan Sponsor and/or the insurance company for such determinations. If there are any errors or omissions in this Form, the Plan Sponsor and FIA reserve the right to correct such errors or omissions. In addition, Plan Sponsor reserves the right to unilaterally amend, change, or terminate the health benefit plans, any underlying contracts or any other programs, at any time and without notice, at its sole discretion, according to the terms of the applicable plans or programs. Please note that this information is provided to you for general informational purposes only and should not be considered an individualized recommendation or personalized advice. No warranty or representation, express or implied, is made by Frost Insurance Agency, Inc. or Frost Bank, nor does Frost Insurance Agency, Inc. or Frost Bank accept any liability with respect to the information set forth herein. Distribution hereof does not constitute legal, tax, accounting, investment, insurance or other professional advice. Recipients should consult their professional advisors prior to acting on the information set forth herein.