

DIOCESE OF SHREVEPORT

DECLARATION OF INTENT TO ENROLL IN GROUP HEALTH INSURANCE

My signature below confirms that I have received notification of Open Enrollment for Group Health Insurance and that I have received a packet that includes a summary of benefits available through the Diocese of Shreveport plan. I have also indicated my choice to enroll or decline enrollment.

Due to the fact that our group health insurance runs through a cafeteria plan, which makes premiums non-taxable, I understand that I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election)

_____ I choose to enroll in the group health insurance plan offered by the Diocese of Shreveport. I understand that my portion of the health insurance premium will be paid through payroll deduction. My enrollment form is attached.

_____ I choose not to enroll in the group health insurance plan offered by the Diocese of Shreveport at this time.

Employee signature

Date

