DIOCESE OF SHREVEPORT
EEOC EMPLOYEE IDENTIFICATION FORM

*****PLEASE PRINT*****

EMPLOYEE NAME: ☐

GENDER:

- MALE ☐
- FEMALE ☐

RACE: ***Select ONE***

- WHITE (NOT OF HISPANIC ORIGIN) ☐
- BLACK (NOT OF HISPANIC ORIGIN) ☐
- HISPANIC ☐
- ASIAN OR PACIFIC ISLANDER ☐
- AMERICAN INDIAN OR ALASKAN NATIVE ☐

JOB CATEGORY: ***Select ONE***

- OFFICIAL/MANAGER ☐
- PROFESSIONAL ☐
- TECHNICIAN ☐
- SALES WORKER ☐
- OFFICE/CLERICAL ☐
- CRAFT WORKER (SKILLED) ☐
- OPERATIVE (SEMI-SKILLED) ☐
- LABORER (UNSKILLED) ☐
- SERVICE WORKER ☐

DIOCESE OF SHREVEPORT

NEW EMPLOYEE NOTIFICATION

DATE:

TO: Peggy Ray, Benefits Manager

FROM:

Effective ____________________

Dept/Parish/School __________________ **Position** __________________

Prior service within Diocese of Shreveport? (give location & dates)

____

Name ____

Address ____

____

SSN _________________ **Date of Birth** _______________________

Gender____ **Salary/Wage** ____________ **Hours worked per week** _____

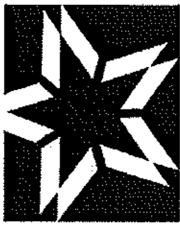
Marital Status: **M** **S** **D** **W** **(Circle One)**

Eligibility for employer retirement contributions met? _____

% level ____ **Annual leave earning rate** ___________

All employees are eligible for voluntary participation in the diocesan retirement plan and workers' compensation insurance. Those who work 20 hours a week or more are eligible for additional benefits. Employers should obtain information on these programs from the Office of Human Resources and/or Benefits Manager.

THIS FORM MUST BE SUBMITTED WITHIN 14 DAYS OF HIRE



CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax

Request for Group Coverage/Enrollment Form

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain provisions contained within this plan may or may not apply while you are covered. PLEASE READ THE FOLLOWING CAREFULLY.

If you have a condition for which medical advice, diagnosis, care, or treatment was recommended or received within three months before your enrollment date and within three months after your effective date with the CBEBT, you will be subject to pre-existing condition exclusion. A pre-existing condition exclusion period is the amount of time when payment for service related to that condition is limited. The exclusion period from the date of enrollment will be: 12 months for timely entrants (individuals who enroll when first eligible); or 6 months deferral period plus 12 months for late entrants (See Late Entrant/Prior Waiver Form). The pre-existing exclusion will not apply to (a) newborns or children under the age of 18 who are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption, or placement for adoption; or (b) pregnancy.

The pre-existing exclusion period may be reduced by the number of days you were covered under a prior health plan. You have the right to demonstrate coverage under a prior health plan. To do this, you may request a certificate of coverage from a prior health plan or insurer. When it is received, please forward a copy of this certificate to our office. Once the length of prior creditable coverage has been determined, you will receive a notice from us stating the length of your pre-existing condition exclusion period, if any.

SPECIAL ENROLLMENT RIGHTS

If you are a part-time employee, you can waive coverage. However, if you are a full-time employee, you may not waive coverage for yourself.

If you waive (or decline) enrollment for yourself or your dependents because of other health coverage, you may later enroll within 31 days of a loss of other health coverage. Loss of health coverage includes separation, divorce, death, termination of employment, reduction in work hours, exhaustion of COBRA continuation or state continuation, or if employer contributions toward your coverage have terminated.

In addition, any change in your family status may allow you to enroll within 31 days of the event. It includes marriage. birth, adoption, or placement for adoption of a child. (See Special Enrollment Form)

With the Onset of the **Children's Health Insurance Program Reauthorization Act of 2009** two additional enrollment opportunities apply for CBEBT Trust members and their enrolled dependents if either of the following occurs:

- Termination of Medicaid or Children's Health Insurance Program **(CHIP)** due to loss of eligibility; or
- Become eligible for state premium assistance under Medicaid or **CHIP.**

Trust members and their dependents who are eligible but not enrolled for coverage under the Christian Brothers Employee Benefit Trust are allowed up to **60 days** to request coverage under the group health plan.

If enrollment is not made at the time these special enrollment opportunities occur, you may apply for coverage via a Late Entrant/Prior Waiver Form. Benefits will not be effective until the first of the month following a 6 month deferral period. The 6 month deferral period begins on the day we receive the form. Once enrolled, there will be a 12 month pre-existing condition period (less prior creditable coverage if applicable) and deferred dental.

Please contact your employer for any clarification regarding your enrollment in the CBEBT.

Please read and fill out ALL applicable sections carefully.

1. Employer Section

Please print or type.

Location Name:		Location#:	
Employee's Name:			
Employee's Home Address	Street:		
City:	State:	Zip Code:	
Employee's Soc. Sec. #:		Date of Birth:	
First Active Day of Work:	**Enrollment Use Only**	Effective Date of Coverage:	
☐Male☐Female	☐Religious ☐Single ☐Married ☐Widowed ☐Divorced		
Annual Salary:			
Email Address:		Home Phone:	

2. Employee Section

I request to be covered under the Group Plan for medical, dental, and vision coverage's:

☐ Employee Only **or** ☐ Employee and Spouse
☐ Employee and Child(ren)
☐ Employee, Spouse and Child(ren)

Please Complete section below if selecting dependent coverage. **Must be completed entirely or can result in delay.**

List the name of each dependent and answer each question for each dependent.	Social Security Number	Birthdate MM/DD/YY	Sex F/M	Natural/ Adopted Child	Full-Time Student	Are you legal Guardian	Step child	Handi-capped	Resides in your home permanently
Spouse:									
List Children Below									
1.									
2.									
3.									
4.									
5.									
6.									

NOTE: Dependents age 19 and over must meet Eligibility requirements as defined in Your Employee Benefits Booklet. For Step-Children or any child for whom you have legal guardianship, a *DEPENDENT ELIGIBILITY FORM* must also be completed. If you are required to complete the Dependent Eligibility Form, coverage will not take effect until after approved by **CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST** in writing.

Signature of Employee:		Date:	

3. Waiver Of Group Coverage

I hereby certify that I have been given an opportunity to apply for group coverage. I understand that if I waive coverage at this time, future coverage may be delayed. I decline to enroll:

☐ Myself ☐ My Dependents for Coverage(s) because:

☐ Enrolled on Spouse's Plan ☐ Individual Policy ☐ Medicare ☐ Medicaid
☐ Enrolled with another employer plan ☐ Other (please explain____________________

Effective Date:		Signature of Employee:		Date:	

4. Life Insurance

PLEASE NOTE: DO NOT USE THIS FORM TO CHANGE THE BENEFICIARY DESIGNATION.

Employer Name:		Location #:	
Employee Name:			
Social Security #:			

Beneficiary (Give full name and relationship to member insured):

____

____

____

____

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving member.

Signature of Employee:		Date:	

POPULAR BENEFICIARY DESIGNATIONS (SEE NEXT PAGE)

Popular Beneficiary Designations

Be sure to use given names such as "Mary M. Doe", not Mrs. John Doe". The following sample designations may be helpful to you.

Type of Beneficiary	Standard Wording
1. insured's estate	my estate
2. one beneficiary	Anna L. Doe wife
3. two beneficiaries	John A. Doe, father, and Mary I. Doe, mother, equally or to the survivor
4. three or more beneficiaries	John A. Doe, father, and Mary I. Doe, mother, and Henry J. Doe, son, equally or to the survivor(s)
5. one beneficiary and one contingent beneficiary	Anna L. Doe, wife, if living; otherwise, Henry J. Doe, son
6. one beneficiary and two or more contingent beneficiaries	Anna L. Doe, wife, if living, otherwise Henry J. Doe, son, Alice G. Doe, daughter, equally or to the survivor
7. one beneficiary and three or more contingent beneficiaries	Anna L. Doe, wife, if living, otherwise Henry J. Doe, Alice G. Doe and Charles B. Doe, children, equally or to the survivor(s)
8. two beneficiaries and one contingent beneficiary	John A Doe, father, and Mary I. Doe, mother, equally or to the survivor; otherwise, Anna L. Doe, wife
9. two beneficiaries in unequal portions	three-quarters of the proceeds to John A. Doe, father, if living, and one-quarter to Anna L. Doe, mother, if living, the share of a deceased beneficiary to be paid to the survivor, if any
10. trust with individual trustees	Richard Doe and John Smith, trustees, or a successor in trust under (trust name) established (date of trust agreement)
11. present or living trust	ABC Bank and Trust Company, Des Moines, Iowa, trustee or successor in trust under (trust name) established (date of trust agreement), provided however that the company has received within 180 days of the death of the insured, evidence satisfactory to the existence of such trust; otherwise to the estate of the insured.
12. testamentary trust	Trustee of the Mary L. Doe trust or successor in trust established by the last will and testament of the insured dated........
13. minor beneficiaries	When either the primary or contingent beneficiary designation includes one or more minor children, you need to complete an additional form, beneficiary designation with UTMA custodian. Please contact CBEBS for this form.

5. Other Coverage/ Authorization To Release Information

As a new participant of the Christian Brothers Employee Benefit Trust, it is necessary for you to complete the information requested below. Failure to do so will result in a delay in processing your initial request for benefits.			
Employee Name:		Location #:	
Employee SSN:			
Employee Address:			

Other Coverage Information

Please **x** one of the following categories and provide the requested information if it applies.

☐Single ☐ Widowed ☐Divorced ☐ Religious

☐ Married(Spouse's Name):		Birth Date:	
Social Security #:			

Do you have any additional Employers?	☐Yes ☐ No	If yes, please provide name address and telephone number.
Do you or any dependent children have any other coverage (including AARP)?	☐Yes ☐ No	If yes, please provide name address and telephone number.
Is your spouse employed?	☐Yes ☐ No	If yes, please provide name address and telephone number.
Spouse's other coverage (including AARP)?	☐Yes ☐ No	If yes, please provide name address and telephone number.

ANY CHANGE IN OTHER COVERAGE INFORMATION MUST BE REPORTED TO OUR OFFICE.

I HEREBY CERTIFY THAT ALL INFORMATION, STATEMENTS AND ANSWERS MADE ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.	Signed (Employee)	Date
AUTHORIZATION TO RELEASE INFORMATION: I authorize any physician, hospital, or other health care provider to release to Christian Brothers Employee Benefit Trust, or its representative, any information regarding my medical history, symptoms, treatment, examination results, or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for one year from the date signed. I understand I have a right to received a copy of this authorization.	Signed (Employee)	Date

Christian Brothers Employee Benefit Trust History

The ***Christian Brothers Employee Benefit Trust (CBEBT)*** was established on January 1,1977, by the Christian Brothers. It began in 1966 as a collective effort to provide a comprehensive package of Employee Benefits to the employees of the Christian Brothers schools. As the news spread of the benefits and savings received by participating in a large group, it was opened in 1977 to any Catholic institution registered in the Kenedy Catholic Directory nationwide.

The **CBEBT** has evolved into a cooperative effort of Catholic organizations continuously working together to provide a package of benefits for their employees in a cost-effective manner.

The **CBEBT** is governed by a board of Trustees who have been elected by the members of the Trust. The Trustees have contracted with ***Christian Brothers Services*** to act as the Plan Administrator for the Trust. ***Employee Benefit Services*** is the division of ***Christian Brothers Services*** that administers all the benefits plans funded by the Trust.

Christian Brothers Services Mission Statement

The Mission of ***Christian Brothers Services*** is to serve the Catholic Community by helping to fulfill organizational and managerial needs through the development of quality, cost-effective, innovative programs and administrative services.

We accomplish this mission in collaboration with other Catholic organizations by combining leadership and insight with the practice of good business principles and belief in the tenets of the Catholic Church.

Important Phone Numbers

Customer Service/Benefit Information..800/807/0400
Christian Brothers Employee Benefit Services
1205 Windham Parkway, Romeoville, IL 60446-1679

AMERIFLEX®

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Save

Print

Company Name: ______________________________

Employee Name: ______________________ Telephone: ______________

Employee Address: ______________________________

City: ______________________ State: __________ Zip: __________

Social Security Number: ______________ Date of Birth: __________ Date of Hire: __________

Plan Year From: __________ To: __________ Effective Date: __________

The Company and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement). I understand that if I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan and therefore cause me to pay un-reimbursed medical, dependent care, and/or commuter expenses (if any) with after-tax dollars.

EMPLOYEE'S FLEXIBLE BENEFIT PER PAY DEDUCTION/ALLOCATION

Medical Reimbursement Account Per pay contribution $ __________ Date of first payroll __________

$__________ Maximum ANNUAL Contribution Annual contribution $ __________ Number or remaining pays __________

Dependent Care Reimbursement Account Per pay contribution $ __________ Date of first payroll __________

$__________ Maximum ANNUAL Contribution Annual contribution $ __________ Number or remaining pays __________

Commuter Reimbursement Account

PARKING Per pay contribution $ __________ Date of first payroll __________

$__________ Maximum MONTHLY Contribution Annual contribution $ __________ Number or remaining pays __________

TRANSIT Per pay contribution $ __________ Date of first payroll __________

$__________ Maximum MONTHLY Contribution Annual contribution $ __________ Number or remaining pays __________

I UNDERSTAND THAT:

(1) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.

(2) 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).

(3) The Plan Administrator may reduce, cancel, or otherwise modify this agreement in the event he/she believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).

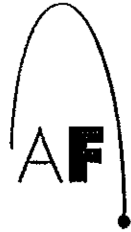
By signing this form I agree to the terms and procedures listed herein.

___ I was given the opportunity to participate in this Flexible Benefits Plan, and I have decided not to participate at this time.

____

Employee Signature Date

■ FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM continued . . .



ADDITIONAL CARDS (only applicable if your employer has chosen this option)

If you wish to have an AmeriFlex Convenience Card® issued for a spouse or dependent, please be sure your spouse or dependent meet these IRS eligibility guidelines:

1. For federal tax purposes, a "spouse" is defined as, ". . . a person of the opposite sex who is a husband or wife." Same sex domestic partners are not considered spouses for purposes of FSA administration. A person residing in the employee's home, who the employee provides over half of their support, who is not the employee's spouse, under applicable state law and is not a family member, is considered a dependent under Internal Revenue Code 152.

2. For federal tax purposes, a "dependent" includes any relative of the participant for whom the participant provides over half of their support for the calendar year. "Relative" includes children, parents, stepchildren, stepparents, siblings, aunts, uncles, cousins, and in-laws of the participant. Relatives do not need to reside with the participant in order to be dependents, nor do they need to be of a certain age or infirmity; they need only to be persons for whom the participant has provided over half of their support.

All Dependents must be over the age of 18 in order to receive an AmeriFlex Convenience Card®

Spouse Name: ______________________ Soc Sec Number: __________ Date of Birth __________

Address to issue card (if different than participant) ____

Telephone: ______________________

Dependent Name: ______________________ Soc Sec Number: __________ Date of Birth __________

Address to issue card (if different than participant) ____

Telephone: ______________________

Dependent Name: ______________________ Soc Sec Number: __________ Date of Birth __________

Address to issue card (if different than participant) ____

Telephone: ______________________

*Please return to your Benefits/Human Resource administrator

■ AUTHORIZATION AGREEMENT FOR ACH DEBITS/CREDITS

I, hereby authorize AmeriFlex, LLC, hereafter called ADMINISTRATOR, to initiate debits and/or credits to or from my Bank Account indicated below at the depository financial institution named below, hereinafter call DEPOSITORY, and to debit and or credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge the the origination of ACH transactions to or from my account must comply with the provisions of U.S. law.

Depository Name ______________________ Account Name ______________________

City ______________________ State ______________ Zip ______________

Routing Number ______________________ Account Number ______________________

☐ Checking Account ☐ Savings Account SELECT ONE

CHECK EXAMPLE

⑆123456789 routing number ⑈0000123456 account number ⑆1234 check number

This authorization is to remain in full force and effect until the ADMINISTRATOR has received written notification from the employee named above of the termination in such time and in such manner as to afford the ADMINISTRATOR and DEPOSITORY a reasonable opportunity to act on it.

____

Employee Signature Date

Upon receipt, the Federal Reserve requires 14 business days to perform the initial approval of the ACH information. After this time, AmeriFlex will be directly depositing all claim reimbursements into the bank account provided two days after every processing date determined by your employer. It may take up to 5 business days to have your reimbursements appear in your account, depending upon the automated clearing house utilized by your bank. We suggest that you contact your bank to confirm when these funds become available in your account. AmeriFlex shall not be responsible for any checks or other debt payments you make whereby you have assumed these funds are available.

DIOCESE OF SHREVEPORT

SEXUAL ABUSE OF MINORS POLICY

COMPLIANCE FORM FOR ALL EMPLOYEES AND VOLUNTEER STAFF

CONFIDENTIAL

Prior to beginning service, every clergyman, employee, and volunteer of the Diocese of Shreveport must be informed of the diocesan Sexual Abuse of Minors policies. Please read and answer the following questions. Once you have completed and signed the form, it will be placed in your employee/volunteer file.

1. Have you received and read the *Diocesan Policy Concerning Sexual Abuse of Minors by Clerics, Employees, or Commissioned Volunteers*?

   YES________ NO________

2. Have you ever been accused of, or arrested for, physically, sexually, or emotionally abusing a child or an adult?

   YES________ NO________

   If YES, explain on the back side of this form.

3. I understand the policy and voluntarily agree to abide by and conduct myself in complete accordance with it.

   YES________ NO________

______________________________	______________________________
SIGNATURE	DATE
______________________________	______________________________
PRINT NAME	EMPLOYMENT/VOLUNTEER LOCATION

11/03

OMB No. 1615-0047; Expires 06/30/09

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) ____________
- ☐ An alien authorized to work (Alien # or Admission #) ____________ until (expiration date, if applicable - *month/day/year*)

Employee's Signature

Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* ____________ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*		Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: ____________ Document #: ____________ Expiration Date *(if any)*: ____________

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*