ANGLICAN DIOCESE OF SOUTH CAROLINA

Anglican Diocese of South Carolina 2026 Benefits Election Form

Reason for Election

☐ New Election	☐ Open Enrollment	☐ Termination	☐ Qualifying Life Event
Change/Reason _____		Date of Hire: _____	Effective Date: _____

Employee Data

Social Security Number	**Last Name**	**First Name**	**Middle**	**Date of Birth**
Home Address		**City**	**State**	**Zip**
Primary Phone Number	**Email**		☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** **Marital Status**	
Church Name	**Church Address**		**Church Phone Number**	

Benefit Elections

CIGNA 1000 $1,000/ $2,000 Deductible	☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline
CIGNA 3500 $3,500/ $7,000 Deductible	☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline
CIGNA 5000 HDHP $5,000/ $10,000	☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline
SunLife Dental Plan	☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline
SunLife Vision Plan	☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline

Reason for Waiving: ☐ Cost ☐ Not Interested ☐ Other Coverage

I understand that if I waive benefits at this time that I will have to wait for our next open enrollment or until I have a qualifying event.
**Enrolling in the Voluntary Life/AD&D outside of your new hire enrollment opportunity may require you to complete Evidence of Insurability. Approval for the benefit is not guaranteed.*

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Worksite Benefit Elections

Voluntary Accident	☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline
Voluntary Critical Illness	☐ Employee Only $____________	☐ Employee + Spouse $____________	☐ Employee + Child(ren) ** Automatic 50% of employee benefit	☐ Employee + Family	☐ Decline
Voluntary Hospital Indemnity	☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	☐ Decline

	Name	Sex	Birth Date	Social Security Number	Medicare	Medicare Claim #	Medical	Dental	Vol Acc.	Vol C.I.	Vol H.I.
Spouse					☐ Yes ☐ No		☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
Child					☐ Yes ☐ No		☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
Child					☐ Yes ☐ No		☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
Child					☐ Yes ☐ No		☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
Child					☐ Yes ☐ No		☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop

** Child insurance is AUTOMATIC. A separate premium is not required.

Please enroll me for the Benefit Options indicated on this form. I understand the benefits and limitations by the various plans/coverages, and I authorize my employer to make the necessary adjustments in my pay, based on the choices I have made and the deduction amounts provided to me, receipt of which is hereby acknowledged. I am an eligible employee working the required hours per week for my employer. I understand that according to federal law, I cannot change my Section 125/Cafeteria benefit plan choices during the plan year unless that change or revocation is on account of and consistent with a Special Enrollment or a change in status.

IMPORTANT HIPAA NOTICE: If you decline enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if that coverage is lost, provided that after the other coverage ends you request enrollment within 60 days for Medicaid or a state children's health program or within 30 days for all other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. I understand that my employer reserves the right to adjust my premiums as a result of plan changes, or changes in my employment such as classification, annual pay, or location. I certify that all information provided is complete and accurate to the best of my knowledge.

Employee Signature: **X**____ Date: ____________________

Once completed please forward to Susan Burns at sburns@adosc.org.