Diocese of Lafayette - Food & Nutrition Services

BENEFIT ELECTIONS ACTION FORM
For Calendar Year 2018

Employee Name: ____

Last Four Digits Social Security # _______________________________________

Please indicate one of the following:

☐ **I DO NOT WISH TO MAKE ANY CHANGES TO MY BENEFITS FOR THE 2018 CALENDAR YEAR.** NO ACTION IS NECESSARY**.**

I understand that if NO changes are being made during this open enrollment period, I will automatically retain my current level of coverage for the upcoming calendar year and further changes cannot be allowed unless I experience a qualifying life event.

____

Signature   Date

☐ **I WISH TO MAKE CHANGES TO THE FOLLOWING FOR THE 2018 CALENDAR YEAR:**

- ☐ One America (Retirement)
- ☐ Blue Cross Blue Shield (Health Insurance)
- ☐ Humana Dental
- ☐ Humana Vision
- ☐ Hartford Life/AD&D
- ☐ Hartford Long Term Disability
- ☐ Hartford Short Term Disability
- ☐ Aflac
- ☐ W-4 Federal Withholdings
- ☐ L-4 State Withholdings
- ☐ Beneficiary on Record
- ☐ Personal Information

I understand that any request for change indicated above is ONLY a request. I understand that, in order for these changes to become effective, I must complete and sign the appropriate forms to formally execute these changes.

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Signature   Date