

ROMAN CATHOLIC DIOCESE OF LEXINGTON

EMPLOYMENT INFORMATION

For Employee to Complete

Name: _____

Street Address: _____

City: _____ County of Residence: _____ State: _____ Zip Code: _____

Home Phone: _____ Email: _____

Social Security Number: _____ Date of Birth: _____

Emergency Contact Name: _____

Relationship to Employee: _____

Emergency Contact Phone Number(s): _____

For Location to Complete

Pay Rate: _____ Location: _____ Diocesan Region: _____

Date of Hire: _____ Start Date: _____ Reports to : _____

Full Time: _____ 37.5 plus hours 100% Job Description: _____

Part Time: _____ Under 20 hours and is not eligible for benefits

_____ 20 to 25 hours 60%	_____ 26 to 29 hours 70%
_____ 30 to 33 hours 80%	_____ 34 to 37 hours 90%

Who enters & approves payroll: _____ Dept #: _____

Previously employed by Diocese: _____ How long: _____ Where: _____

**Work Email if employee will be receiving correspondence from Secretariat for Stewardship (contact person for payroll, attend MBA meetings, etc.)* _____

Signature of Supervisor

Date

For Risk Management Use Only

File # _____

PLEASE PRINT OR TYPE

PARTICIPATION WAIVER FORM

Name _____ SSN _____/_____/_____

Address _____

City _____ State _____ Zip _____

Phone _____ Gender _____ Date of Birth _____

Most recent Date of Diocesan Hire _____

If previously employed with the Diocese, please complete an Employment Record Form.

By signing this form, I elect NOT to participate in the above plan at this time and I understand the following:

- I understand that by signing this form I will **NOT** receive a pension benefit from the Diocese upon leaving the employment of the Diocese.
- I understand that any contributions that may have been withheld from my paychecks prior to the receipt of this form, will be refunded to me through payroll provided that this form was submitted within 60 days of my date of hire.
- Under IRS guidelines, if you are eligible to participate in this plan but do not do so because you elect not to make the required contribution, you are still considered an active participant in the plan. Therefore, your W-2 will reflect your status as active and your ability to establish an IRA may be affected. We advise you to consult your tax accountant.

→ Employee Signature _____ Date _____
(Do not print)

THIS FORM MUST BE RECEIVED BY YOUR PAYROLL DEPARTMENT WITHIN 60 DAYS OF YOUR DATE OF HIRE. AFTER SUCH DATE YOU MUST CONTACT NYHART (1-800-428-7106) IN ORDER TO WITHDRAW FROM THE PLAN.

For Office Use Only

Parish/School _____

Employee ID/File Number _____

→ Verified By _____ Date _____
(Plan Representative or Payroll Dept)

BENEFICIARY DESIGNATION FORM

Name: _____ SSN _____

Address: _____

City _____ State _____ Zip _____

Single Married Date of Marriage: _____

Primary Beneficiary:

Name: _____

Address: _____

Relationship: _____

Secondary Beneficiary:

Name: _____

Address: _____

Relationship: _____

I reserve the right to change my beneficiary designation shown above at anytime. (Call Nyhart at 1-800-428-7106 ext 3575)

→ Employee Signature _____ Date _____
(Do not print)

→ Witness Signature _____ Date _____
Cannot be Beneficiary (Do not print)

EMPLOYMENT RECORD FORM

Name _____ SSN _____/_____/_____

Most recent Date of Diocesan Hire _____

Previously employed by the Diocese? NO YES

If YES, please provide the information requested below regarding your previous years of employment with the Diocese (beginning with your present employment). This information is necessary to verify and credit you with the appropriate number of years of employment with a parish, school, agency or institution which participates in this plan.

Employment Date (month/year): From _____ To _____

Parish/School _____

Location _____

Position _____

Employment Date (month/year): From _____ To _____

Parish/School _____

Location _____

Position _____

Employment Date (month/year): From _____ To _____

Parish/School _____

Location _____

Position _____

Employment Date (month/year): From _____ To _____

Parish/School _____

Location _____

Position _____

→ Employee Signature _____ Date _____

CDLEX Billing

Full Name: Noreen Brown
Last Name: Brown
First Name: Noreen
Company: Nyhart

Business Address: 8415 Allison Pointe Blvd.
Suite 300
Indianapolis, IN 46250

Business: (317) 845-3575
Business 2: (800) 428-7106
Business Fax: (317) 845-3654

E-mail: noreen.brown@nyhart.com
E-mail Display As: Noreen Brown (noreen.brown@nyhart.com)

Web Page: www.nyhart.com

Form W-4 (2012)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at www.irs.gov/w4. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____
B	Enter "1" if: <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B _____
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit	F _____
(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)		
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three to seven eligible children or less "2" if you have eight or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child 	G _____
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H _____
<p>For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. </p>		

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service	<h2>Employee's Withholding Allowance Certificate</h2> <p>▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <h1 style="font-size: 2em;">2012</h1>
1 Your first name and middle initial _____ Last name _____		2 Your social security number _____
Home address (number and street or rural route) _____		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code _____		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) _____		5 _____
6 Additional amount, if any, you want withheld from each paycheck _____		6 \$ _____
7 I claim exemption from withholding for 2012, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 _____
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶ _____		Date ▶ _____
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) _____		9 Office code (optional) _____
		10 Employer identification number (EIN) _____

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$ _____
2	Enter: $\left\{ \begin{array}{l} \$11,900 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,700 \text{ if head of household} \\ \$5,950 \text{ if single or married filing separately} \end{array} \right\}$	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3	\$ _____
4	Enter an estimate of your 2012 adjustments to income and any additional standard deduction (see Pub. 505)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2012 Form W-4</i> worksheet in Pub. 505.)	5	\$ _____
6	Enter an estimate of your 2012 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter "-0-"	7	\$ _____
8	Divide the amount on line 7 by \$3,800 and enter the result here. Drop any fraction	8	_____
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9	_____
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	_____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3"	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	_____

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$8,000	0	\$0 - \$70,000	\$570	\$0 - \$35,000	\$570
5,001 - 12,000	1	8,001 - 15,000	1	70,001 - 125,000	950	35,001 - 90,000	950
12,001 - 22,000	2	15,001 - 25,000	2	125,001 - 190,000	1,060	90,001 - 170,000	1,060
22,001 - 25,000	3	25,001 - 30,000	3	190,001 - 340,000	1,250	170,001 - 375,000	1,250
25,001 - 30,000	4	30,001 - 40,000	4	340,001 and over	1,330	375,001 and over	1,330
30,001 - 40,000	5	40,001 - 50,000	5				
40,001 - 48,000	6	50,001 - 65,000	6				
48,001 - 55,000	7	65,001 - 80,000	7				
55,001 - 65,000	8	80,001 - 95,000	8				
65,001 - 72,000	9	95,001 - 120,000	9				
72,001 - 85,000	10	120,001 and over	10				
85,001 - 97,000	11						
97,001 - 110,000	12						
110,001 - 120,000	13						
120,001 - 135,000	14						
135,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

KENTUCKY DEPARTMENT OF REVENUE
EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Payroll No. _____

Print Full Name _____

Social Security No. _____

Print Home Address _____

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

EMPLOYEE:

Failure to file this form with your employer will result in withholding tax deductions from your wages at the maximum rate.

1. If SINGLE, and you claim an exemption, enter "1," if you do not, enter "0"
2. If MARRIED, one exemption each for you and spouse if not claimed on another certificate.

- (a) If you claim both of these exemptions, enter "2" }
- (b) If you claim one of these exemptions, enter "1" }
- (c) If you claim neither of these exemptions, enter "0" }

3. Exemptions for age and blindness (applicable only to you and your spouse but not to dependents):
 - (a) If you or your spouse will be 65 years of age or older at the end of the year, and you claim this exemption, enter "2"; if both will be 65 or older, and you claim both of these exemptions, enter "4"
 - (b) If you or your spouse are blind, and you claim this exemption, enter "2"; if both are blind, and you claim both of these exemptions, enter "4"
4. If you claim exemptions for one or more dependents, enter the number of such exemptions
5. National Guard exemption (see instruction 1)
6. Exemptions for Excess Itemized Deductions (Form K-4A)

EMPLOYER:

Keep this certificate with your records.

7. Add the number of exemptions which you have claimed above and enter the total
8. Additional withholding per pay period under agreement with employer. See instruction 1\$

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date _____

Signed _____

INSTRUCTIONS

1. NUMBER OF EXEMPTIONS—Do not claim more than the correct number of exemptions. However, if you have unusually large amounts of itemized deductions, you may claim additional exemptions to avoid excess withholding. You may also claim an additional exemption if you will be a member of the Kentucky National Guard at the end of the year. If you expect to owe more income tax for the year than will be withheld, you may increase the withholding by claiming a smaller number of exemptions or you may enter into an agreement with your employer to have additional amounts withheld. If you claim more than 10 exemptions this information is sent to the Department of Revenue.

2. CHANGES IN EXEMPTIONS—You may file a new certificate at any time if the number of your exemptions **INCREASES**.

You must file a new certificate within 10 days if the number of exemptions previously claimed by you **DECREASES** for any of the following reasons.

(a) You are divorced or legally separated from your spouse for whom you have been claiming an exemption or your spouse claims his or her own exemption on a separate certificate.

(b) The support of a dependent for whom you claimed exemption is taken over by someone else, so that you no longer expect to furnish more than half the support for the year.

(c) Your itemized deductions substantially decrease and a Form K-4A has previously been filed.

OTHER DECREASES in exemption, such as the death of a spouse or a dependent, do not affect your withholding until the next year, but require the filing of a new certificate by December 1 of the year in which they occur.

3. DEPENDENTS—To qualify as your dependent (line 4 on reverse), a person (a) must receive more than one-half of his or her support from you for the year, and (b) must not be claimed as an exemption by such person's spouse, and (c) must be a citizen of the United States, or a resident of the United States, Canada, or Mexico, or (d) must have lived with you for the entire year as a member of your household or be related to you as follows:

- your child, stepchild, legally adopted child, foster child (if he lived in your home as a member of the family for the entire year), grandchild, son-in-law, or daughter-in-law;
- your father, mother, or ancestor of either, stepfather, stepmother, father-in-law, or mother-in-law;
- your brother, sister, stepbrother, stepsister, brother-in-law, or sister-in-law;
- your uncle, aunt, nephew, or niece (but only if related by blood).

4. PENALTIES—Penalties are imposed for willfully supplying false information or willful failure to supply information which would reduce the withholding exemption.

www.revenue.ky.gov



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) _____
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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) _____

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

Documents that Establish Both
Identity and Employment
Authorization

LIST B

Documents that Establish
Identity

LIST C

Documents that Establish
Employment Authorization

	OR	AND	
1. U.S. Passport or U.S. Passport Card	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States	
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)	
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		3. School ID card with a photograph	4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form		4. Voter's registration card	
		5. U.S. Military card or draft record	
	6. Military dependent's ID card		
	7. U.S. Coast Guard Merchant Mariner Card	5. Native American tribal document	
	8. Native American tribal document	6. U.S. Citizen ID Card (Form I-197)	
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	9. Driver's license issued by a Canadian government authority	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)	
	For persons under age 18 who are unable to present a document listed above:	8. Employment authorization document issued by the Department of Homeland Security	
	10. School record or report card		
	11. Clinic, doctor, or hospital record		
	12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

ROMAN CATHOLIC DIOCESE OF LEXINGTON

The Roman Catholic Diocese of Lexington is offering direct deposit to your bank account. Please attach a voided check for direct deposit to your checking account. For a direct deposit to your savings account attach a deposit slip with your bank name, account number and routing number. When voiding the check or savings deposit slip be sure that you do not in any way damage or delete any of the magnetic ink numbers at the bottom. The bank requires ALL of those numbers. On savings accounts ask your bank if the routing number is included on the bottom line, if not, write it in. If you wish to have a portion of your direct deposit sent to your savings account, indicate the amount per pay period, which will remain the same for the entire year.

EXPLANATION OF DIRECT DEPOSIT: The entire amount of the employee's Paycheck is automatically deposited into his/her bank account (checking and/or savings) on payday. The employee does not have to go to the bank. The employee can access the I-Pay system to view their pay stub, which shows deductions and the net amount deposited into his/her bank account.

ROMAN CATHOLIC DIOCESE OF LEXINGTON

PAYROLL DIRECT DEPOSIT AUTHORIZATION FORM

I, _____ hereby authorize the Roman Catholic Diocese of Lexington to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my checking savings account indicated by the enclosed check or deposit form.

This authority is to remain in full force and effect until the Roman Catholic Diocese of Lexington has received written notification from me of its termination in such time and in such manner as to afford the diocese a reasonable opportunity to act on it.

Employee Signature _____ Date _____

Employee Enrollment / Change Form

Benefits Administered by



ENROLLMENT SERVICES
PO BOX 8052 • WAUSAU WI 54402-8052

- Initial Group COBRA Open Enrollment
 New Employee Change (complete change section on reverse side)

Employer	EMPLOYER NAME ROMAN CATHOLIC DIOCESE OF LEXINGTON		GROUP NUMBER 76530007		EMPLOYEE JOB LOCATION	
	EMPLOYEE START DATE	EARNINGS	HOURS WORKED WEEKLY	JOB TITLE		
Employee	SOCIAL SECURITY NUMBER			ALTERNATE IDENTIFICATION NUMBER		
	NAME: LAST		FIRST	M.I.		
	ADDRESS		CITY	STATE	ZIP	E-MAIL ADDRESS
	DATE OF BIRTH	SEX	MARITAL STATUS	HOME TELEPHONE NUMBER		
Portability	This Health Plan has a Pre-existing illness provision for 12 months or 18 months. Proof of Creditable Health Coverage may reduce this time period.					
	Have you attached a Certificate of Creditable Health Coverage for You and/or all Dependents? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, contact your prior plan/employer or insurer to obtain a copy. If necessary, we will assist you. If a certificate is not available, other forms of proof may be submitted.					
Other Health Coverage	Do you or any family member currently have other health coverage? <input type="checkbox"/> Yes, single <input type="checkbox"/> Yes, family <input type="checkbox"/> No					
	If yes to the above question, complete the following: Person's Name _____ Plan Number _____ Employer Name _____ Carrier Name _____					
Other Dental Coverage	Do you or any family member currently have other dental coverage? <input type="checkbox"/> Yes, single <input type="checkbox"/> Yes, family <input type="checkbox"/> No					
	If yes to the above question, complete the following: Person's Name _____ Plan Number _____ Employer Name _____ Carrier Name _____					
Coverages	Health Coverage:					
	<input type="checkbox"/> Medical Plan Class # _____ <input type="checkbox"/> Employee <input type="checkbox"/> Employee plus one <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Employee plus child/children <input type="checkbox"/> Family <input type="checkbox"/> Waive					

IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.

BD0114
09-06

Page 1
See next page
3/3/09

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

Dependents	Last	First	MI	SS#	BIRTH DATE	GENDER	Relationship to Employee	Do you claim this dependent as an exemption for Federal incometax purposes?	Do you provide more than 50% Support?
	Spouse Name					/ /			
Child Name					/ /				
2					/ /				
3					/ /				
4					/ /				
5					/ /				

Indicate any dependent children listed above who are 19 or older and are full-time students. Please complete the questions below for student status.

1. Is the dependent child a full-time student? _____
2. How many credits and what semester is dependent child registered for? _____
3. What is the actual or anticipated graduation date? _____
4. What is the school name? _____

COMPLETE THIS SECTION IF MAKING CHANGES

Effective date of change: _____ Please specify change and update in appropriate section.

Employee name change Employee address change Job location change Job title change Earnings change

Return to work Beneficiary change Other coverage change Date of marriage _____

Other _____ Date of divorce _____

Add dependents Remove dependents (list names) _____ Reason: _____

Add coverage Voluntarily Terminate coverage (Indicate which coverages) _____ State/Federal Continuation

Employee Signature Required _____

Employment termination: Reason: _____ Last day worked _____ Date coverage terminated _____

WAIVING COVERAGE

Important: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes.

If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPAA Special Enrollment because of loss of that coverage. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage:

I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage.

For specific plan language contact your Human Resources Representative

CERTIFICATION: I freely and voluntarily waive all coverage noted above.

EMPLOYEE SIGNATURE

DATE

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

EMPLOYEE SIGNATURE

DATE

BD0114
10-07

Roman Catholic Diocese of Lexington

Certification of Tobacco Usage

Roman Catholic Diocese of Lexington Health Insurance -- Tobacco Usage Premium

As a participant in the Roman Catholic Diocese of Lexington's Health Insurance Plan, a \$15 per month premium will be assessed to those employees who use a tobacco product and/or to those employees that have a family member on the plan who uses a tobacco product. Tobacco products include: cigarettes, cigars, chewing tobacco and other smokeless tobacco. The \$15 premium will be payroll deducted each month beginning June 15, 2006, and monthly thereafter.

It is the employee's responsibility to request and complete an updated certification should the employee or a family member on the plan begin the use of tobacco products or if the employee or a family member discontinues the use of tobacco products.

I hereby authorize my employer to make the necessary deductions for the contribution to the Roman Catholic Diocese of Lexington's Health Insurance Plan for myself or a family member that uses a tobacco product.

Tobacco Usage	
_____ Signature of employee	_____ Date
Yes, I certify that myself or	
a family member, _____, on	
Name(s) of the family member	
the Roman Catholic Diocese of Lexington's Health Insurance Plan uses a tobacco product. I certify that this statement is true and correct to the best of my knowledge.	

No Tobacco Usage	
_____ Signature of employee	_____ Date
No, I certify that myself	
and all family members on the Roman Catholic Diocese of Lexington's Health Insurance Plan do not use any tobacco products. I certify that this statement is true and correct to the best of my knowledge.	

Employee's Printed Name

Location Where Employed
(Name of Church/School)

Return with health enrollment to: Roman Catholic Diocese of Lexington
Risk Management Office
1310 W. Main St.
Lexington, KY 40508-2048



CATHOLIC DIOCESE OF LEXINGTON ENROLLMENT/STATUS CHANGE FORM

Delta Dental Premier

Delta Dental Premier is offered by Delta Dental of Kentucky, Inc.

DeltaCare

DeltaCare is offered by Dental Choice, Inc.

OPEN ENROLLMENT NEW ENROLLMENT STATUS CHANGE COBRA _____

Complete Status Change information below.

COBRA effective date.

Social Security Number	Name - Last	First	MI	Birthdate	/ /
Home Address - Number and Street		City	State	Zip	Group Number 676260
Sex (Circle one) M or F	Employer Name CATHOLIC DIOCESE OF LEXINGTON		Hire Date Required	Section Number	

Check the type of contract and list all members:

Single Employee and Spouse Employee and child Employee and children Family

MEMBERS Please list all dependents below, if applicable. If additional space is required, attach a list to this form.

Last	First	MI	Spouse or Dependent Social Security Number	Date of Birth MO DAY YR	Sex M F	FULL-TIME STUDENT YES* NO	STATUS CHANGES ONLY (Circle one)	Does member have other dental coverage? If so, give insurance company name and telephone number, policyholder's name and identification number.
Spouse							ADD DELETE	
Dependent							ADD DELETE	
Dependent							ADD DELETE	
Dependent							ADD DELETE	
Dependent							ADD DELETE	

***Dependent children coverage requiring student verification once they have turned age 19 must submit proof of full-time school enrollment. A signed Delta Dental affidavit is acceptable.**

STATUS CHANGES ONLY (Complete all that apply. Qualifying event required.)

Indicate new contract type below and add or delete dependents in MEMBERS grid above:

Single Employee and Spouse Employee and child Employee and children Family

Qualifying Event: _____ QE Effective Date: _____

Terminate Subscriber's Contract as of _____

Name Change: Previous Name: _____ New Name: _____

Address Change: _____

SHADED AREA FOR OFFICE USE ONLY

Effective Date	Process Date	Processed By
----------------	--------------	--------------

**READ THE PROVISIONS ON THE BACK OF THIS ENROLLMENT FORM CAREFULLY BEFORE SIGNING.
PLEASE REVIEW YOUR ENROLLMENT FORM FOR ERRORS OR OMISSIONS.**

I acknowledge I have read the provisions on the back of this enrollment form and I expressly accept such provisions as a condition of coverage. I represent the answers given to all questions on this form are true and accurate to the best of my knowledge and I understand they are being relied on by Dental Choice (DeltaCare) or Delta Dental (Delta Dental Premier and Delta Dental PPO) in accepting this form. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). If accepted, this form, the member certificate, the identification card, and the group contract will constitute the contract.

Signature _____ Date _____

Please make a copy for your records and return original to your Human Resources Director.

ENROLLMENT FORM FOR GROUP COVERAGE

In consideration of the acceptance of this enrollment form, I represent and agree for myself and my dependents that:

1. My coverage, and that of any dependents, will become effective on the date established by my dental contract (referred to as "Plan"). I agree to be bound by the provisions of the Group Contract(s) and Certificates of Coverage issued to me. Any dependents who are later added to my Plan may have different effective dates.
2. If I have selected the DeltaCare plan, my coverage provides for coordination of covered services through a designated Primary Care Dentist and benefits for services covered under the program will be provided only when furnished by the participating dentist I have designated on the reverse side. I also understand that no benefits are available under this coverage if I or any dependents fail to receive services through a Primary Care Dentist.
3. If I have selected the DeltaCare plan, I am entitled to select a new Primary Care Dentist at any time during my coverage period.

If I have selected the Delta Dental Premier or Delta Dental PPO plan, I understand that all benefits payable under my dental contract for services rendered by any participating provider will be paid to such provider. Payment for services rendered by a non-participating provider will be sent to me.
4. My employer or group administrator is authorized to deduct my share of dental premiums from my wages for 12 months and 12 month renewal periods, and is authorized to remit a premium to the Plan and to receive all notices from the Plan relating to my coverage. I understand that enrollments are by Group Contract for consecutive 12 month period(s) and my subscription fee is subject to change on the anniversary date of the Group. Further, I understand that non-compliance with these terms would void any benefits during that enrollment period.
5. I am responsible to notify the Plan upon any change that would make me or any dependent ineligible for coverage.
6. I will cooperate with the Plan and furnish all information requested by the Plan to enforce its right of subrogation and to coordinate benefits. Subrogation is the Plan's right to recover from a third party that may be liable to me for any injury which resulted in Dental Services paid by Plan.
7. I will reimburse the Plan for any erroneous payment and Plan may offset these amounts against future claim payments.
8. Any omitted or incorrect information or false statements made here may, at the sole option of the Plan, void or terminate my coverage or result in denial of services or benefits otherwise available hereunder for me or my dependents. I understand that if I have Delta Dental or Dental Choice coverage on an employee paid (voluntary) plan and I terminate my coverage before the end of any 12-month enrollment period while I am still eligible to participate in the Group Contract, my benefits will be voided for the entire enrollment period, and I must reimburse my Primary Care Dentist, or the Plan if the Plan has already paid the dentist, at the dentist's normal fee for service, for any services or benefits received by me or my dependents during that 12-month period. I consent that any subscription fees paid to the Plan during that period will be retained by the Plan to cover administration expenses. I understand and agree that no agent has the authority to waive a complete answer to any question, make a determination as to applicable underwriting requirements, make or alter any contract, or waive any of the Plan's other rights or requirements.
9. My employer, any other organization or person, any provider of dental care, any insurance company or insurance support agency, is hereby authorized to give the Plan any information about me and my listed dependents necessary for determining eligibility for insurance, benefits, risk classification, detecting or preventing fraud or misrepresentation, audits, and for claims administration purposes. This authorization includes any records or knowledge about my medical history, mental or physical condition, diagnosis, treatment or prognosis, including information relating to the use of drugs or alcohol. This information may also be given by the Plan to its legal representatives and reinsurers.
10. To the extent allowed by law, the Plan is authorized to furnish all information and copies of records requested by other insurers, dental plans or other parties for the purposes of determining eligibility for coverage or benefits; exercising the right of subrogation, utilization review or audit. I give the Plan, its legal representatives or any person or organization administering claims on its behalf, permission to release to my employer or group policyholder a summary of claims incurred by me or my eligible dependents for the purpose of verifying the claims submitted under my group health plan, utilization review, or for the purpose of conducting an audit of operations or services. If my benefits are provided under a self-funded plan, the above listed parties are authorized to release any necessary information to the self-funded plan, and I understand that all information under the Plan are the property of my employer and may be retained by my employer.
11. Any material misrepresentation found in this application may result in denial of benefits or cancellation of my coverage(s). Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. If accepted, this application, the identification card and the group contract will constitute the contract.

PLEASE SIGN APPLICATION ON FRONT

3/3/09

Roman Catholic Diocese of Lexington

MEMORANDUM

**IMPORTANT INFORMATION ABOUT YOUR
PROTECTED HEALTH INFORMATION
RESPONSE REQUIRED**

TO: Priests Enrolled in Health, Dental, Vision, and/or Long-Term Care Insurance
Employees Enrolled in Health and/or Dental Insurance
COBRA Participants and Electees
All Diocesan Locations

FROM: Bill Wakefield, CFO and HIPAA Compliance Officer

DATE: September 30, 2008

RE: Federal Government HIPAA (Health Insurance Portability and
Accountability Act) Privacy Regulations

You may be aware that there are federal regulations that require the protection of your protected health information (PHI). The enclosed notice and form are part of the Roman Catholic Diocese of Lexington's compliance requirements.

The "Notice of Privacy Practices" describes how your PHI may be used and disclosed. It also explains how you can access your PHI. Please read the notice carefully, sign and date the form indicating you have received the privacy notice, and return to the Risk Management Office **within 10 days of receipt**. You can keep a copy for your records. Forms can be mailed and envelopes must be clearly marked for "Risk Management".

Also enclosed is the form "Standard Authorization to Disclose Protected Health Information". This form can be copied and **kept for later use**. It will be used when you need a representative of the insurance company to assist you with claims issues. It will be required that you submit this form each and every time that you require assistance with claims issues that you have not been able to resolve on your own. If a spouse normally handles your routine business affairs, this form will be required to have him/her discuss your PHI. You may want to call Bill at 859-253-1993, ext. 238, to discuss the completion of the form since each person that needs to work on your claim must be listed.

Roman Catholic Diocese of Lexington

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. *Roman Catholic Diocese of Lexington* is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:
 - a. For treatment -- *N/A*
 - b. For payment -- *To resolve claims issues and payments for claims.*
 - c. For health care operations -- *To renew insurance coverages and reinsurance coverages.*
2. *Roman Catholic Diocese of Lexington* is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. *[If a use or disclosure for any purpose prescribed in the Privacy Regulation is prohibited or materially limited by other applicable State law, the description of such use or disclosure must reflect the more stringent law.]*
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. *Roman Catholic Diocese of Lexington* intends to engage in one or more of the following activities:
 - a. *Roman Catholic Diocese of Lexington* may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
 - b. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
5. The individual has the following rights regarding protected health information:
 - a. The right to request restrictions on certain uses and disclosures of protected health information. *Roman Catholic Diocese of Lexington* is not required to agree to a requested restriction, however.
 - b. The right to receive confidential communications of protected health information, as applicable.
 - c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
 - d. The right to amend protected health information, as provided in the Privacy Regulation.
 - e. The right to receive an accounting of disclosures of protected health information.
 - f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.
6. *Roman Catholic Diocese of Lexington* is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.
7. *Roman Catholic Diocese of Lexington* is required to abide by the terms of the Notice currently in effect.
8. *Roman Catholic Diocese of Lexington* reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.

9. *Roman Catholic Diocese of Lexington* will provide individuals or patients with a revised Notice by *mail*.
10. Individuals may complain to *Roman Catholic Diocese of Lexington* and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows: *contact the Chief Financial Officer of the Roman Catholic Diocese of Lexington by mail or phone with the nature of the complaint and the name of the person (if applicable) that the complaint is against.*
11. *Roman Catholic Diocese of Lexington's* contact person for matters relating to complaints is:
 - a. *Chief Financial Officer*
 - b. *859-253-1993, ext. 238*
 - c. *Roman Catholic Diocese of Lexington, 1310 W. Main St., Lexington, KY 40508-2048*
12. This Notice is first in effect on *April 10, 2004*.
13. *Roman Catholic Diocese of Lexington* elects to limit the uses or disclosures that it is permitted to make, as follows: *Third Party Administrator for Self-funded Health Insurance Plan(s) or Insurance Carrier for Fully Insured Health Plan(s); Dental Insurance Carrier(s); Vision Insurance Carrier(s); Long-term Care Insurance Carrier(s); Reinsurance Carrier(s) for Self-funded Health Plan; Insurance Broker(s).*

I hereby acknowledge that I have received a copy of *Roman Catholic Diocese of Lexington's* Notice of Privacy Practices.

Individual's Name - Signature

Individual's Name - Printed

Date: _____

Please return this form to Risk Management, Roman Catholic Diocese of Lexington, 1310 W. Main St., Lexington, KY 40508-2048. Forms are to be returned within 10 days of receipt.

Although every effort has been made to ensure that this document template is complete and accurate according to the HIPAA regulation, it does not constitute legal advice and, therefore, should be reviewed by an attorney competent in HIPAA-related matters. You are authorized to use these documents only if you and the business you work for have a valid password and have accepted the terms of the HIPAAAnswers™ Product Use Agreement. Your use of these documents is controlled by the Product Use Agreement. For example, although you can save and reproduce the HIPAAAnswers™ documents for your internal business purposes, you are not authorized to share copies of these documents with anyone outside your business. For complete details, review HIPAAAnswers™ Product Use Agreement.

ID521

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Employee Application



ASSURANT Employee Benefits

G. O. no. _____

Group policy/participant no.	Account no.	Cert. no.	Employer	Employment location/phone no.
Employee name (last, first, initial)		Part-time employ. date Month Day Year	Full-time employ. date Month Day Year	Employee date of birth Month Day Year
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Children <input type="checkbox"/> Yes <input type="checkbox"/> No	Earnings <input type="checkbox"/> Hourly No. hrs. per week _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other _____	Employee Soc. Sec. no. State of residence
Job title or position				

Status: (if status area is not completed, we consider the employee to be active.)

Retired Continuation Leave of absence Other _____

Reason _____ Date _____

Please mark X in box before the coverages you are applying for if you are eligible for them under your employer's plan:

Employee: Life Accidental Death & Dismemberment Optional/Additional Life Amt. _____
 Short Term Disability Long Term Disability Optional Amount: STD LTD Amt. _____
 Dental

Dependent: Life Dental Please mark X in box before the dependents to be covered: Spouse Children

If spouse coverage is being applied for, complete the following.

Name of Spouse	Date of Birth Month Day Year	Social Security No.	Employer	Current Dental Insurance Carrier

Write in the names and dates of birth of children to be covered (subject to plan provisions).

Were you covered under another dental plan within the last 31 days? Yes No

If "Yes," termination date _____ Reason for termination of other coverage _____

Note— Coverages not specifically elected will not be made effective, even if not refused.
 ELECTIONS NOT VALID WITHOUT SIGNATURE.

Write in any coverages being refused and reason for refusal.

BENEFICIARIES (Please read information below before completing.)

Last name	First	Mi	Relationship*	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

*If beneficiary is not related to you, please provide Date of Birth, Social Security number, and full address.

1) Give FULL names and relationships of each beneficiary. 2) If primary/secondary election is not noted, the beneficiary will be considered primary. 3) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. 4) If your designation does not fit in the above arrangement, please contact Union Security Insurance Company for the appropriate forms.

IMPORTANT NOTICE TO APPLICANTS—PLEASE READ CAREFULLY

My signature on this application certifies that I:

1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. 2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of the Late Entrant Limitation period specified in the policy. 3) Authorize any required deductions from my earnings. 4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. 5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. 6) Understand that I must be actively at work the number of hours specified in my policy/participation agreement to remain insured. 7) Understand that I have the right to select any dental care provider of my choice. 8) Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed. 9) When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

This will certify that I HAVE read and understand the above important notice.

Signature _____

Date _____



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - KY

Company name Diocese of Lexington	Division level	Account number/unit number H33308
--------------------------------------	----------------	--------------------------------------

Employee Information

Name		Social security number	
Mailing address (street)		Birth date	<input type="checkbox"/> male <input type="checkbox"/> female
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date employed full-time	Hours worked per week	Job occupation/class	Location
Salary amount	Salary mode <input type="checkbox"/> yearly <input type="checkbox"/> weekly <input type="checkbox"/> hourly <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly		
What is your payroll mode? <input type="checkbox"/> monthly <input type="checkbox"/> semi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly		Employer ZIP	Employer county

Short Term Disability

Employee: XX Elect

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.

- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. All statements by or on behalf of the insured shall be deemed to be representations and not warranties. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claims payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers for myself and/or my dependents will be used by Principal Life only as allowed by law.

A copy of this form will be as valid as the original.

I represent that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Principal Life.

Your signature X _____ Date Signed _____

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

Roman Catholic Diocese of Lexington

The following document is in a box on our website, www.cdlex.org. The box is titled Employee Handbook and Code of Conduct.

Handbook Acknowledgement

I acknowledge that I am aware of my responsibility to read and understand the policies and procedures as outlined in The Roman Catholic Diocese of Lexington's Employee Handbook. I understand that, upon request, I may meet with my manager/supervisor or contact the Secretary for Pastoral Life and/or their designee to review the personnel policies and procedures.

I understand that the policies and procedures as published on the web site supercede any previous handbook, policies or procedures that may have been effective in the past.

I understand and acknowledge that the Roman Catholic Diocese of Lexington uses the handbook and personnel policies and procedures as "guides to provide information to employees". I understand and acknowledge that the Diocese retains complete discretion to apply, change, or interpret handbook provisions, policy, and personnel practices consistent with the needs of its staffing and any legal counsel on such matters.

I acknowledge and understand that my employment is at will, meaning that either the Diocese or I can terminate the employment relationship at any time for any reason.

Employee Signature/Position

Date

Protecting personal information

- I _____ acknowledge I am responsible to comply with federal and state laws to protect personal private information that I may come in contact with during the performance of my responsibilities within the Catholic Diocese of Lexington
- Furthermore, I will do my best to maintain vigilance protecting personal private information that is accessed by me in the exercise of my job and ministry. I will guard in confidence the identity information that I handle or am exposed to in the scope of my responsibilities.
- I will promptly report any suspected compromise or actual compromise of personal private information to the Pastor, Pastoral Director, Principal, or Business Manager as soon as possible.

• Signed: _____ Date: _____

Parish/School/Entity _____



ROMAN CATHOLIC DIOCESE OF LEXINGTON

NEW TEACHER CHECKLIST

Mail all forms to: Risk Management Office
The Catholic Center
1310 W. Main St.
Lexington, KY 40508

- _____ Teacher Application
- _____ Official, original (not a copy) Kentucky Certification
- _____ Catholic Schools Office Staff Only: Type _____ Expiration _____
- a. ___ Out of state teachers must have a Form TC-1 for Kentucky Certification
- b. ___ First year teachers on internship must send the RED Statement of Eligibility (SOE)
- _____ Transcripts of degree work (i.e. Bachelor's, Master's, etc.) supplied by new hire
- _____ Verification of Experience - if salary credit is to be given for previous experience the hiring school should send the verification form to each school district or diocesan office in which the applicant was employed.
- _____ FBI Background Check (See School Background Check Requirements)
- _____ Tuberculin (TB) skin test results
- _____ Catechist Training form (Form supplied by the Diocesan Director of Religious Education)
- _____ Signed contract
- _____ Employee Information Sheet completed
- _____ W4
- _____ K4
- _____ I-9 with clear copies of identification
- _____ Direct Deposit Form with voided check
- _____ Code of Conduct Acknowledgement
- _____ Acknowledgement of Handbook
- _____ Health Enrollment Form Accepting or Waiving Coverage
- _____ Life Insurance/Short Term Disability Enrollment Form
- _____ Tobacco Usage
- _____ HIPAA Form
- _____ Dental, if accepting coverage
- _____ Protecting Personal Information Acknowledgement

Roman Catholic Diocese of Lexington

The Employee Handbook can be found on the diocesan website, www.cdlex.org, located in a box titled

Employee Handbook and Code of Conduct.

Read this document, then SIGN and DATE the acknowledgement below.

Code of Conduct Acknowledgement

I understand that it is my responsibility to read the Code of Conduct and understand its contents. I understand that, upon request, I may meet with my Parish, School or Diocesan leadership to review the Code.

CERTIFICATION

I hereby attest and certify that I have never been accused of, convicted of, or pled guilty to: sexual abuse, gross sexual imposition, voyeurism, public indecency, or any existing or former offense of any municipal corporation, this state or any other state of the United States that is substantially equivalent to any of the above offenses. (If you have been accused of, convicted of, or pled guilty to any of the above offenses and wish to explain the circumstances thereof, please do so on a separate sheet.) I further certify that I have never been discharged from employment or a volunteer position because of any activity covered by the foregoing statutes.

I hereby authorize any present or former employer, person, firm, corporation, physician, or government agency to answer all questions and to release or provide any information within their knowledge or records dealing with the above-named areas of conduct, and I agree to hold any and all of them harmless and free of any liability for releasing any information that is within their knowledge and records. I further authorize the Roman Catholic Diocese of Lexington to conduct a check of my police criminal records in accordance with KRS 156.483, KRS 17.160, and KRS 17.165 at state and federal levels.

I hereby attest and certify that the above information provided by me is true and correct to the best of my knowledge. I understand that misrepresentations or omissions may disqualify my application or result in my immediate dismissal if I am already employed.

Signature and Date

Parish, School or Diocesan Office

Print Name

Witness