Diocese of Albany	Acknowledgement and Refusal of Health Benefits Form
Office of Human Resources	ADM-28

Name: _____

Department, Parish or School: _____

Position: _____ Location: _____

Social Security Number (last 4 digits): _____ Date of Hire: _____/_____/ _____

I acknowledge I have been offered the opportunity to enroll myself and eligible family members in the Roman Catholic Diocese of Albany Group Health Plan. This form needs to be completed by every eligible employee (20 hours or more per week).

Please check one of the following boxes.

☐ 1. I wish to keep my current heath care coverage through The Roman Catholic Diocese of Albany.

☐ 2. I am not currently enrolled in a health care plan through The Roman Catholic Diocese of Albany but wish to sign up.

☐ 3. I am currently enrolled in The Roman Catholic Diocese of Albany health plan but would like to switch coverage.

☐ 4. I have been offered an opportunity to join the Diocesan Lay Employees Health Insurance Plan and do not wish to join. I understand that unless my circumstances change, I will not be offered an opportunity to join again until the next open enrollment period, or earlier, should the circumstances warrant it.

Signature: _____ Date: _____

NOTE: *THE ORIGINAL COPY IS RETAINED IN THE EMPLOYEE'S PERSONEL FOLDER. THIS FORM NEEDS TO BE COMPLETED **ANNUALLY** DURING THE OPEN ENROLLMENT PERIOD.*