

**DIOCESE OF BATON ROUGE**  
**ELECTION NOT TO PARTICIPATE IN BENEFITS**

(Revised 7/2009)

*Instructions: Complete this form for each employee who is eligible for the benefits noted below but chooses not to participate. The employee must check and sign each benefit that he/she elects not to participate in. Once completed, the employer (or proper delegate) must also sign and dates the form and file it in the employee's Personnel File.*

Parish/ School/ Unit Name \_\_\_\_\_ Location \_\_\_\_\_

I, \_\_\_\_\_, hereby elect **not** to participate in the benefit programs marked below  
*(Print employee's full name)*

*(check appropriate box and sign each applicable section):*

1a.  Group Health Insurance Program – I further certify that I am covered by other group health insurance. I hereby hold harmless the Diocese of Baton Rouge for any and all health costs incurred by me, my spouse, and dependents.

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date Signed*

1b.  Health Saving Account (HSA)

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date Signed*

2.  Premium Conversion Plan

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date Signed*

3.  Dental Insurance Plan

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date Signed*

4.  401 (k) Retirement Plan (not Traditional or Roth or any combination)

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date Signed*

5.  Optional Life Insurance Plan

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date Signed*

6.  Optional Short Term Disability Plan

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date Signed*

\_\_\_\_\_  
*Signature of Employer or Employer's Representative*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Date Signed*