# MINISTRY EMPLOYER MEMBERSHIP APPLICATION

(for those not listed in the Official Catholic Directory)

Name of Ministry: _____

Address: _____

_____

_____

Name of Representative: _____

Position of Representative: _____

Phone: _____

Email: _____

The ministry hereby applies, for itself and for its related ecclesiastical organizations, and its separately incorporated related ministries and activities ("related employers"), for membership in the Catholic Benefits Association.

The organization represents, for itself and its related employers, that (please initial EACH):

_____ Catholics (or trusts or other entities wholly controlled by Catholics) own 51% or more of the employer and related employers;

_____ 51% or more of the employers' and related employers' governing bodies, if any, are Catholic; and,

_____ The organization represents, for itself and its related employers that, with regard to the practices, policies, and benefits they have or provide to their respective employees or others and with regard to any health care services they provide to patients, they, as part of their religious witness and exercise, are committed to implementing and providing no such employment practices, policies, benefits, or services inconsistent with Catholic values; and that they shall support efforts to preserve the right of Catholic organizations to do so.

.

_____The organization understands that should the three qualifications for membership, initialed above, change in any way, the organization must notify Catholic Benefits Association immediately to determine continued qualification for membership.

Catholic Benefits ASSOCIATION

THE POWER OF ASSOCIATION™

As a condition for membership in the Association, the ministry agrees to pay dues and assessments to the Association based on the number of employees enrolled on the relevant employer-sponsored health plan(s). Dues to be paid, as determined by the Association's board of directors, and which, as of the date of this application, are:

| NUMBER OF EMPLOYEES | 1-14 employees | 15 or more employees |
|---|---|---|
| MEMBERSHIP DUES | **$300/year** | $1.50 per month per enrolled employee, Capped at **$4000/month** |

If the ministry has no health plan or is a sole proprietor, the minimum amount will apply.

The ministry hereby represents that it has authority to apply for membership in the Association for itself and its related employers.

The ministry hereby represents that its related employers which it intends to be included as members of the Association are identified on Schedule A.

The total number of covered employees for the ministry and the related employers is_____.

A "covered employee" is an employee participating in a health plan sponsored or maintained by the ministry or a health plan sponsored or maintained by any related employer. This number shall be updated annually or with significant changes reported by the ministry.

_____ _____

Name of diocese or ministry Date

_____ _____

Representative signature Position

_____

Representative name (printed)

Catholic Benefits ASSOCIATION

THE POWER OF ASSOCIATION™

# Schedule A

## RELATED EMPLOYERS TO BE ADMITTED AS MEMBERS

The applicant ministry identifies the following related employers and acknowledges that pursuant to this application for membership, each of them should be admitted as a member of the Catholic Benefits Association:

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

If any related employer is a for-profit entity, please write “for profit” behind the entity’s name.

Catholic Benefits ASSOCIATION
THE POWER OF ASSOCIATION™

# NEW MEMBER BILLING PREFERENCES

New member dues are assessed after the first full month of membership. Membership dues are billed in arears for the preceding month and are sent on the first of each month. You can specify below the billing preference for your organization.

1. How often would you prefer to be billed? **(Circle one):**

   Monthly

   Annually (first billed will be prorated for the remaining months of the current year)

2. Who should we reference when sending your invoice:

   Name: _____

   Position: _____

   Email Address: _____

3. Our invoices are typically emailed; however, you can indicate if you would prefer mailed invoices instead (Check only as needed):

   ☐ Please email invoices to (if different from above):

   Name: _____

   Email Address: _____

   ☐ Please mail invoices to the attention of:

   Name: _____

RETURN COMPLETED APPLICATIONS: mandycox@catholicbenefitsassociation.org

OR

695 Jerry Street Suite 306
Castle Rock, Colorado 80104