



DIOCESE OR MINISTRY EMPLOYER MEMBERSHIP APPLICATION

(for those 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 ministry represents, for itself and its related employers that they are Catholic 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.

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, except that its parishes need not be separately listed.

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)



Schedule A

RELATED EMPLOYERS TO BE ADMITTED AS MEMBERS

The applicant ministry identifies the following related employers (other than parishes, which need not be separately identified) 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.

PARISHES: Regardless whether they are separately incorporated, parishes of a ministry applicant will be members of the Association, and need not be listed on this Schedule A. If a diocese or archdiocese seeks to exclude a parish as a member of the Association, it should provide the Association written direction to that effect.

DIOCESE, ARCHDIOCESE, EPARCHY: In the case of a **diocese, archdiocese or eparchy**, related employers include separately incorporated ministries, such as, by way of example, Catholic Charities, other Catholic relief organizations, schools, elder care facilities, cemetery associations, housing agencies and others. In the case of other religious institutes and non-diocesan non-profit entities, separately incorporated related employers should be identified.



NEW MEMBER BILLING PREFERENCES

New member dues are assessed after the first full month of membership. Membership dues are billed in arrears 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

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