



**Roman Catholic Archdiocese of Boston
BAS MyEnroll Request to Add a Class Code**

Location Name _____

RCAB Institution Number _____

Please provide the employee cost if the employee were to enroll in the following:

Individual Health* _____ %

Family Health* _____ %

Individual Dental _____ %

Family Dental _____ %

Effective date of change(s): _____

***Increases of more than 5% over the employee cost share in place as of March 2010 are not permitted due to grandfathered status under the PPACA.**

Authorized Signer Name

Authorized Signer Signature

Date

Please complete and return to the RCAB Benefits Office via facsimile (617)779-4567 or e-mail at benefits@rcab.org