

PERSONAL INFORMATION

Empl ID _____

Name _____ Soc Sec No. _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Business Phone _____ E-mail _____

Birth Date _____ Gender: M F Married: Y N Date of Marriage _____

DEPENDENT INFORMATION (Dependent verification documents must be submitted with enrollment form)

Relationship	Last (only if different)	First	Birth Date (Mo Day Yr)	Gender	Soc Sec No.	Dep. Ver.
Spouse (Equiv)				M F		
				M F		
				M F		
				M F		
				M F		
				M F		

Please select an insurance carrier and coverage level for each benefit, or select Waive for no coverage.

The amount you pay depends on the university's contribution. See separate price sheet for details.

HEALTH COVERAGE

- MMO Traditional
 Anthem PPO
 Kaiser HMO
 SuperMed PPO
 Waive Medical
- Level of coverage:**
 Employee Only
 Employee + Child(ren)
 Employee + Spouse/Equivalent
 Family

Kaiser only: Employee's Primary Care Physician (PCP) Name: _____ PCP ID: _____

Kaiser only: (circle one: spouse / dependent) PCP Name: _____ PCP ID: _____

Kaiser only: (circle one: spouse / dependent) PCP Name: _____ PCP ID: _____

MEDICARE AND OTHER INSURANCE INFORMATION

Do you or any of your dependents have other health or dental coverage? Yes No If yes, complete below

Name of policy holder _____ Name and address of insurance company _____ Policy No. _____ Effective Date _____ Coverage Type _____

MEDICARE AND OTHER INSURANCE INFORMATION

Medicare/Medicaid coverage: _____ Medicare ID# _____ Effective Date _____ ESRD Onset Date _____

You _____

Your Spouse _____

DENTAL COVERAGE

DenteMax School Dental Med Basic School Dental Med Comprehensive Waive Dental

Level of coverage:

Employee Only Employee + Child(ren) Employee + Spouse/Equivalent Family

VISION COVERAGE

VSP *Level of coverage:* Employee Only Employee + Child(ren) Employee + Spouse/Equivalent Family

Union Eye Care *Level of coverage:* Employee Only Employee + 1 Family

Waive Vision

FLEXIBLE SPENDING ACCOUNT PLANS

Flexible spending account minimum annual contribution is \$120; maximum of \$5,000 per year. Unspent dollars in calendar year are forfeited.

Health Care Monthly pledge _____ Waive Medical FSA

Dependent Care (annual maximum \$2,500 if married filing separate tax returns) Monthly pledge _____ Waive Dependent FSA

LIFE AD/D COVERAGE

Please circle your selection. *Medical evidence of insurability is required for supplemental elections. Maximum coverage allowed is 3 x salary, but not more than \$500,000.*

1X 1.5X 2X 2.5X 3X 50,000 Waive Supplemental Life

DEPENDENT LIFE (Voluntary After-tax Benefit)

\$5,000 Spouse/\$1,000 Child(ren) 0.50/month \$10,000 Spouse/\$2,000 Child(ren) 1.00/month

Waive Dependent Life

PREPAID LEGAL (Voluntary After-tax Benefit)

Hyatt Legal Plan \$17.50/month Waive Prepaid Legal

EMPLOYEE SIGNATURE

I understand that by signing and submitting this form within the first 30 days of employment, I am making a binding election concerning my benefits until such time as I elect new coverage and sign a new form. If I elected to waive medical coverage, I certify that my family and I have other coverage.

Signature _____ Date _____

**Return completed enrollment form and dependent verification documents to
Benefits, 224 Crawford Hall, LC 7047.**

CASE BENEFITS ADMINISTRATION

Date of Hire _____

Employee Class _____

Effective Date of Coverage _____

Assigned Benefit Program _____

Benefits Representative Signature _____ Date _____