

You have **30 days after your change** of status to notify Benefits Administration and change your Benelect choices. As noted in your Benelect Guide, the benefit choices you make are in effect for one calendar year and may be changed only during the annual enrollment period to take effect for the following year. The exception to this Internal Revenue Service regulation is a change in family or job status, which allows you to make the appropriate benefit changes mid-year. Only changes that are on account of and correspond with the documented family or job status event can be made. Qualifying life event changes are marriage, divorce, birth or adoption of your child, death of a covered family member, change in child dependent status, or loss of your spouse health care coverage.

PERSONAL INFORMATION

Name		Empl ID	
Address		Soc.Sec.No.	
City	State	Zip Code	
Home Phone	Business Phone	E-mail	
Birth Date	Gender: M F	Married: Y N	Date of Marriage

LIFE EVENT (*Please provide a brief explanation of the life event circumstances and date of event in the space provided. Documentation verifying the date of event must accompany this change of status form.*)

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. Recd
Spouse (Equiv)			/ /	M F		
			/ /	M F		
			/ /	M F		
			/ /	M F		
			/ /	M F		

For each benefit please select a carrier and a level of 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
 Waived
Level of coverage
 Employee Only
 Employee + Ch(ren)
 Employee + Sp/Eq
 Family

DENTAL COVERAGE

DenteMax
 School Dental Med Basic
 School Dental Med Comprehensive
 Waived
Level of Coverage
 Employee Only
 Employee + Ch(ren)
 Employee + Sp/Eq
 Family

VISION COVERAGE

VSP
 Employee Only
 Employee + Ch(ren)
 Employee + Sp/Eq.
 Family
 Union Eye Care
 1 Person
 2 Person
 Family
 Waived

MEDICARE AND OTHER INSURANCE INFORMATION

If covered by Medicare/Medicaid:	Medicare ID#.	Effective Date	ESRD Onset Date
You			
Your Spouse			

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	

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 select 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 Waived

DEPENDENT LIFE (Voluntary After-tax Benefit)

- \$5,000 Spouse/\$1,000 Ch(ren) 0.50 \$10,000 Spouse/\$2,000 Ch(ren) 1.00 Waived

EMPLOYEE SIGNATURE

I understand that by signing and submitting this form within 30 days of the qualifying status change, 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 _____