## University of Dayton Benefits Enrollment / Change Form Retirees Eligible for Medicare

Name				UD ID#			
Address				Date of Birth	1		
City/State/Zip				Date of Hire			
Email Address				Social			
				Security #			
Reason for Application				Effective Date:			
□ Qualified I	ife Event □ Retirement □ Open E	nrollment □ Add o	or Remo	ove Depender	nt	coverage	
	<u>Oualified</u>	Life Event – Within	n 30 D	<u>ays</u>			
☐ Marriage / Divorce ☐ Medicare eligible ☐ Dependent loss/gain coverage dependent				ge   Dependent loss/gain employment  Other			
	De	ntal Waiver of Bene	efits				
I have decide	tand the dental plans that are offered d to waive the benefit(s) indicated be qualified life event (QLE). Proof of Q	low. I understand that	at I <u>wil</u>	<u>l<b>l not</b></u> be eligi		lless within	
]	☐ Superior Dental Plan						
Signature:		Da	ate:				
Enrollment: Medical Insurance Options: Anthem				HR Use Only			
□ Medicare Advantage PPO				Effective Date:			
<b>~</b>				Group-Sub-Group #			
Enrollment: Dental Insurance Option: Superior Dental				HR Use Only			
□ Superior Dental Plan (Preferred Plan)				Effective Date:			
□ Single □ Family				Group-Sub-Group #			
List Spouse	and Dependents Below					J	
Relationship	Name	Social Security #	Da	ate of Birth	Add / Remove	Plan	
· · · · · ·		.,			□ Add	□ Medical	
					□ Remove	□ Dental	
					□ Add	□ Medical	
					□ Remove	□ Dental	
					$\square$ Add	□ Medical	
					□ Remove	□ Dental	
					□ Add	□ Medical	
					□ D	□ Dental	
					□ Remove	☐ Dental☐ Medical☐	

 $\square$  Dental

□ Medical□ Dental

□ Remove

 $\square$  Remove

If married, does (did) your spouse work for the University of Dayton in a benefit eligible position?   □ Yes □ No					
Spouse's Status:     Faculty   Staff   Grad Assistant	Spouse's Name:_				
Medicare Part A Effective Date: Part B Effective Date:	Medicare ID #				
Terms, conditions, and authorizations:					
made within this application. I understand that my elections m Resources within 30 days of a qualified life event. I authorize t information necessary to complete the enrollment / disenrollme guarantee of coverage and that the Office of Human Resources	lans, Inc. invoice me for any applicable premiums for the elections ade within this application must be provided to the Office of Human the University of Dayton to communicate to its vendors any ent process. I understand that the completion of this document is not a and its vendors will make the determination on the acceptance of this ources of any life event that might impact my benefit elections and				
This application hereby replaces any previous elections made a 1. My employment / benefit eligible status changes 2. I have a qualified life event and notify HR within 30 3. I fail to make premium payments for my coverage					
I certify that this application is complete with accurate informat denial of benefits.	tion and acknowledge that providing false information can lead to the				

Name: \_\_\_\_\_

ID# \_\_\_\_\_

11/2018

Page **2** of **2**