

2014 - University of Dayton Benefits Enrollment / Change Form Active Employees and Graduate Assistants

Name		UD ID #	
Address		Date of Birth	
City/State/Zip		Date of Hire	
Email Address		Social Security #	

Reason for Application

Effective Date: _____

- New Hire / Rehire
 Qualified Life Event
 New Enrollment
 Open Enrollment
 Court Order
 Add or Remove Dependent
 Drop / Waiver of coverage

Qualified Life Event – Within 30 Days

- Marriage / Divorce
 Birth / Adoption
 Guardianship
 Dependent loss/gain coverage
 Dependent loss/gain employment
 Over-age dependent
 Other _____

Medical / Dental Waiver

I fully understand the medical and dental plans that are offered by the University of Dayton. After careful consideration, I have decided to waive the benefit(s) indicated below. I understand that I **will not** be eligible to re-enroll until the next annual open enrollment period or within 30 days of a qualified life event (QLE). Proof of QLE will be required upon application.

- Anthem Medical Plans
 Superior Dental Plan

Signature: _____ Date: _____

Medical Insurance Options: Anthem

- Core Plan
 Advantage Plan
 Employee Only
 Employee + Spouse
 Employee + Child(ren)
 Family

HR Use Only

Effective Date: _____
Group-Sub-Group # _____

Dental Insurance Option: Superior Dental

- Superior Dental Plan (Preferred Plan)
 Employee Only
 Employee + Spouse
 Employee + Child(ren)
 Family

HR Use Only

Effective Date: _____
Group-Sub-Group # _____

I elect to have my medical and dental premiums withheld on a:

- Pre-tax basis
 After-tax basis

* If no election is made, the default is pre-tax deductions

List Spouse and Dependents Below

Relationship	Name	Social Security #	Date of Birth	Add / Remove	Plan
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Medical <input type="checkbox"/> Dental

If married, does 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:* _____

Medical and Dependent Care Flexible Spending Accounts: My Cafeteria Plan (Graduate Assistants Not Eligible)

Medical FSA Election	Limited Medical FSA	Dependent Care FSA
Max. annual contribution per employee - \$2,500	Max. annual contribution per employee - \$2,500	Max. annual contribution per family - \$5,000
Per pay amount: \$ _____ (Annual amount divided by number of pays remaining in plan year.)	Per pay amount: \$ _____ (Annual amount divided by number of pays remaining in plan year.)	Per pay amount: \$ _____ (Annual amount divided by number of pays remaining in plan year.)
Annual election: \$ _____ (Used for: Qualified healthcare, dental, and vision expenses not covered by insurance)	Annual election: \$ _____ (Used for: Qualified dental and vision expenses while enrolled in spouse's employer HSA Plan)	Annual election: \$ _____ (Used for: Qualified child care or adult elder care so that you and your spouse may work or attend school full-time)

Terms, conditions, and authorizations:

I hereby authorize the University of Dayton to withhold any applicable premiums from my wages for the elections made within this application. I authorize the University of Dayton to withhold these premiums on a pre-tax basis unless otherwise informed by checking the appropriate box on the previous page. I understand that my elections made within this application must be provided to the Office of Human Resources within 30 days of a qualified life event as required by the IRS regulations under Section 125. I authorize the University of Dayton to communicate to its vendors; Anthem, Superior Dental, EyeMed, and MyCafeteria Plan any information necessary to complete the enrollment / disenrollment process. I understand that the completion of this document is not a guarantee of coverage and that the Office of Human Resources and its vendors will make the determination on the acceptance of this request. I know that I am responsible for notifying Human Resources of any life event that might impact my benefit elections and changes needed.

This application hereby replaces any previous elections made and are fixed until:

1. My employment / benefit eligible status changes
2. I have a qualified life event and notify HR within 30 days
3. I make a change during an annual open enrollment
4. I fail to make premium payments for my coverage

I certify that this application is complete with accurate information and acknowledge that providing false information can lead to the denial of benefits and disciplinary action up to and including termination of employment.

Signature: _____ **Date:** _____