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 of Benefits

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:_____

Enrollment: Medical Insurance Options: Anthem

□ Core Plan □ Advantage Plan

□ Employee Only □ Employee + Spouse □ Employee + Child(ren) □ Family

HR Use Only

Effective Date: _____

Group-Sub-Group #_____

Enrollment: Dental Insurance Option: Superior Dental

□ Superior Dental Plan (Preferred Plan)

□ Employee Only □ 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

 Name: _____ ID# _____

List Spouse and Dependents Below

Relationship	Name	Social Security #	Date of Birth	Add / Remove	Plan
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ 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	**Dependent Care FSA**	**Limited Medical FSA**
Max. annual contribution per employee - $2,500 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)	Max. annual contribution per family - $5,000 Per pay amount: $_____ (Annual amount divided by number of pays remaining in plan year.) Annual election: $_____ (Used for: Qualified child care or adult elder care so that you and your spouse may work or attend school full-time)	Max. annual contribution per employee - $2,500 Per pay amount: $_____ (Annual amount divided by number of pays remaining in plan year.) Annual election: $_____ (Used for: Qualified dental and vision expenses while enrolled in spouse's employer HSA Plan)

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 direct deposit is now required for reimbursements under the My Cafeteria Plans and as a result, my direct deposit information currently used by the University for payroll purposes will be utilized. An alternate account may be established by communicating with My Cafeteria Plan directly. 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: _____