University of Dayton Benefits Enrollment / Change Form
Retirees

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

Reason for Application Effective Date: _____

□ Qualified Life Event □ Retirement □ Open Enrollment □ Add or Remove Dependent □ Waiver of coverage

Qualified Life Event – Within 30 Days

□ Marriage / Divorce □ Medicare eligible □ 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 unless 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 □ Medicare Supplement **(Under age 65 only)** □ Retiree Only □ Retiree + Spouse □ Retiree + Child(ren) □ Family	***HR Use Only*** Effective Date: _____ Group-Sub-Group #_____
Enrollment: Dental Insurance Option: Superior Dental □ Superior Dental Plan (Preferred Plan) □ Single □ Family	***HR Use Only*** Effective Date: _____ Group-Sub-Group #_____

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

 Name: _____ ID# _____

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:
I hereby authorize the University of Dayton to have Business Plans, Inc. invoice me for any applicable premiums for the elections made within this application. 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. I authorize the University of Dayton to communicate to its vendors; Anthem, Superior Dental, EyeMed, MyCafeteria Plan, and Ceridian 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 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.

Signature: _____Date: _____

1/2014