

2012 FLEX Benefits Enrollment Application

<input type="checkbox"/> NEW ENROLLMENT	CHANGE REASON: <input type="checkbox"/> Newborn/Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce	EFFECTIVE DATE
<input type="checkbox"/> ENROLLMENT CHANGE	<input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Loss of Student Status <input type="checkbox"/> Other _____	

EMPLOYEE INFORMATION

NAME	HOME ADDRESS <small>Street Apt #</small>
NDID/NET ID	<small>City State Zip code</small>
CAMPUS ADDRESS <small>Building Room #</small>	<small>Country (if outside U.S.)</small>
CAMPUS PHONE (574) 631 - [][][][]	MAILING ADDRESS <small>Street Apt #</small>
MARITAL STATUS <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed	<small>City State Zip code</small>
	HOME PHONE

Benefits Options (Monthly Deductions)

MEDICAL OPTION

	INDIVIDUAL	INDIVIDUAL + 1	FAMILY
MERITAIN PPO—CHOOSE LOCAL NETWORK	<input type="radio"/> \$69.00	<input type="radio"/> \$205.00	<input type="radio"/> \$254.00
CHA NETWORK—MEMORIAL <input type="radio"/> MC			
SELECT NETWORK—ST. JOSEPH <input type="radio"/> MN			
MERITAIN CHA HMO	<input type="radio"/> \$71.00	<input type="radio"/> \$213.00	<input type="radio"/> \$264.00
MERITAIN SELECT HMO	<input type="radio"/> \$52.00	<input type="radio"/> \$152.00	<input type="radio"/> \$190.00
No COVERAGE - NON ND SPOUSE*	<input type="radio"/> \$0.00	<input type="radio"/> \$0.00	<input type="radio"/> \$0.00
No COVERAGE - ND SPOUSE	<input type="radio"/> \$0.00	<input type="radio"/> \$0.00	<input type="radio"/> \$0.00

OTHER COVERAGE VERIFICATION

* = Please attach copy of medical insurance card.

DENTAL OPTION

NOT PARTICIPATING

	INDIVIDUAL	INDIVIDUAL + 1	FAMILY
DELTA PREMIER	<input type="radio"/> \$16.02	<input type="radio"/> \$30.26	<input type="radio"/> \$52.60
DELTA PPO (FORMERLY PREFERRED)	<input type="radio"/> \$20.68	<input type="radio"/> \$37.00	<input type="radio"/> \$66.32

VISION OPTION

NOT PARTICIPATING

	INDIVIDUAL	INDIVIDUAL + 1	FAMILY
EYE MED	<input type="radio"/> \$8.32	<input type="radio"/> \$15.72	<input type="radio"/> \$23.04

FLEXIBLE SPENDING ACCOUNTS (ENTER YOUR ANNUAL CONTRIBUTION FOR THE REMAINDER OF THE CALENDAR YEAR)

NOT PARTICIPATING

Health Care Account (Minimum \$10.00 per month and Maximum \$5,000.00 per employee)	FMC	<input type="radio"/> _____ ANNUAL 2012 DEDUCTION
Dependent Care Account (Minimum \$10.00 per month and Maximum \$5,000.00 per family)	FDC	<input type="radio"/> _____ ANNUAL 2012 DEDUCTION

Dependent Coverage Information

New Enrollment: List all covered dependent(s).

Change: List only the dependent(s) affected by the change(s).

RELATIONSHIP	ADD	DROP	FULL NAME	SSN	BIRTH DATE	M/F	AGE 19 & OVER			PLEASE INDICATE Y/N		
							DISABLED*	MARRIED#	FT STUDENT	MEDICAL	DENTAL	VISION
SELF												
SPOUSE												
DEPENDENT												
DEPENDENT												
DEPENDENT												
DEPENDENT												

* IRS disabled dependent. Contact Human Resources for further instructions.

† 12 credit hours or more for dependents age 19 - 25

Married and unmarried children up to the age of 26 are eligible for medical insurance.

Unmarried full-time students are eligible for vision and dental insurance up to the age of 25.

Life Insurance

If both you and your spouse are employed by the University, you will be insured as an employee only (not as a spouse) and either one, not both, may insure your child(ren).

OPTIONAL LIFE INSURANCE (CHOOSE OPTION 1 - 10 TIMES YOUR ANNUAL SALARY)

NOT PARTICIPATING

SELF - OPTIONAL LIFE (1 - 10X)

LS

OPTION (1 - 10)

COVERAGE AMOUNT

MONTHLY DEDUCTION

DEPENDENT LIFE INSURANCE

NOT PARTICIPATING

SPOUSE - \$12,500.00

LU01

\$5.64

LC01 CHILD(REN) - \$ 5,000.00

\$0.76

SPOUSE - \$25,000.00

LU02

\$11.30

LC02 CHILD(REN) - \$10,000.00

\$1.52

LIFE INSURANCE BENEFICIARY DESIGNATIONS

Please designate at least one Primary Beneficiary for your \$25,000.00 (and any additional) Life Insurance Policy.

My Travel Accident Insurance designation is different (please attach list).

PRIMARY BENEFICIARY

RELATIONSHIP

PERCENTAGE

PRIMARY BENEFICIARY

RELATIONSHIP

PERCENTAGE

ADDRESS

 Street Apt #
 City State Zip code
 Country (if outside U.S.)

ADDRESS

 Street Apt #
 City State Zip code
 Country (if outside U.S.)

EMERGENCY CONTACT INFORMATION

IN EVENT OF EMERGENCY:

NAME

RELATIONSHIP

PHONE

HOME ADDRESS

 Street Apt #
 City State Zip code
 Country (if outside U.S.)

ND ALERT SYSTEM:

ND ALERT CELLPHONE

EXTERNAL PERSONAL
EMAIL ADDRESS

NOTE: ND Alert provides additional means to contact students and employees regarding emergencies on campus. It is important that you provide your personal contact information so emergency alerts can be delivered quickly and accurately.

CERTIFICATION OF PREVIOUS LONG-TERM DISABILITY (LTD) COVERAGE

There is a one year waiting period for LTD Coverage, unless you had LTD for at least one year with a previous employer and coverage terminated within the three months prior to your benefit effective date. If you meet these conditions, please fill in the following information:

I hereby certify that I was previously employed by _____, and was covered under a group long-term total disability benefit plan providing income benefits for a minimum of five years for disability due to sickness.

<i>Insurance Company</i>	<i>Date Coverage Terminated</i>	<i>Initial</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

I have read the materials about my benefits, and I understand that by signing this form, I authorize the elections I made and any deductions from my pay. If I have not elected medical coverage, I certify I have coverage elsewhere. I understand my elections must be made within 31 days of my hire date and that these elections will remain in effect until the next calendar year. If I have elected coverage, I hereby authorize all hospitals, physicians, medical service providers, pharmacists, employers, and all other agencies or organizations (including insurers and pre-paid health plans) to permit Meritain Health, Medco, Delta Dental, and/or Eye Med or their representatives to see or obtain a copy of all medical, prescribed drugs, HIV, mental health diagnoses, and insurance coverage records which pertain to me or any member of my family. This information will be used in connection with claims for benefits and utilization review, and will be kept strictly confidential. This authorization shall remain valid for the terms of this coverage. I understand if a member is injured through the act or omission of another, the above insurers will require reimbursement for benefits provided in an amount not to exceed any damages collected (where permitted by law). I understand that if I experience a qualifying life event that effects my benefits, I am responsible for notifying the Office of Human Resources, and providing documentation, within 31 days of such event. I understand all benefits for myself and my eligible dependents will be provided in accordance with the Group Policy.

SIGNATURE

DATE