

2009 FLEX Benefits Enrollment Application

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

To exclude personal address/phone from the campus telephone directory please check the box(es):

NAME _____
NDID/NET ID _____
CAMPUS ADDRESS _____
Building Room Number
CAMPUS PHONE (574) 631 - _____
MARITAL STATUS
 Single
 Married
 Divorced
 Widowed

HOME ADDRESS

Street Apartment Number

City State ZIP Code

Country (if outside U.S.)

 MAILING ADDRESS

Street Apartment Number

City State ZIP Code

 HOME PHONE _____

NOTE: If this information is left blank or incomplete, your campus information will not appear in the directory system.

EMERGENCY CONTACT INFORMATION

IN EVENT OF EMERGENCY:
NAME _____
RELATIONSHIP _____
PHONE _____
HOME ADDRESS _____
Street Apartment Number

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.

Benefits Options (Monthly Deductions)

MEDICAL OPTION

		<u>INDIVIDUAL</u>	<u>INDIVIDUAL + 1</u>	<u>FAMILY</u>
MERITAIN PPO	MN	<input type="radio"/> \$54.00	<input type="radio"/> \$190.00	<input type="radio"/> \$217.00
MERITAIN CHA HMO	MH	<input type="radio"/> \$48.00	<input type="radio"/> \$180.00	<input type="radio"/> \$198.00
MERITAIN SELECT HMO	MS	<input type="radio"/> \$35.00	<input type="radio"/> \$120.00	<input type="radio"/> \$140.00
NO COVERAGE - NON ND SPOUSE*	OI	<input type="radio"/> (\$33.00)	<input type="radio"/> (\$33.00)	<input type="radio"/> (\$33.00)
NO COVERAGE - ND SPOUSE	ND	<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

		<u>INDIVIDUAL</u>	<u>INDIVIDUAL + 1</u>	<u>FAMILY</u>
DELTA PREMIER PPO	DD	<input type="radio"/> \$15.42	<input type="radio"/> \$27.52	<input type="radio"/> \$50.36
DELTA PREFERRED POS	DP	<input type="radio"/> \$20.02	<input type="radio"/> \$37.52	<input type="radio"/> \$67.94

VISION OPTION

NOT PARTICIPATING

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

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

NOT PARTICIPATING

SELF - OPTIONAL LIFE (1 - 10X)	LS	<input type="radio"/> _____	<input type="radio"/> _____	<input type="radio"/> _____
		OPTION (1 - 10)	COVERAGE AMOUNT	MONTHLY DEDUCTION

DEPENDENT LIFE INSURANCE

NOT PARTICIPATING

SPOUSE - \$12,500.00	LU01	<input type="radio"/> \$3.36	LC01 CHILD(REN) - \$ 5,000.00	<input type="radio"/> \$0.76
SPOUSE - \$25,000.00	LU02	<input type="radio"/> \$6.72	LC02 CHILD(REN) - \$10,000.00	<input type="radio"/> \$1.52

FLEXIBLE SPENDING ACCOUNTS (ENTER YOUR ANNUAL CONTRIBUTION)

NOT PARTICIPATING

Health Care Account (Minimum \$10.00 per month and Maximum \$5,000.00 per employee)	FMC	<input type="radio"/> _____
		ANNUAL DEDUCTION
Dependent Care Account (Minimum \$10.00 per month and Maximum \$5,000.00 per family)	FDC	<input type="radio"/> _____
		ANNUAL 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 †	FT STUDENT ‡	MEDICAL	DENTAL	VISION	
SELF												
SPOUSE *												
DEPENDENT												
DEPENDENT												
DEPENDENT												
DEPENDENT												

* Exclude spouse from the campus telephone directory

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

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

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

CONTINGENT BENEFICIARY

RELATIONSHIP

PERCENTAGE

CONTINGENT BENEFICIARY

RELATIONSHIP

PERCENTAGE

ADDRESS Street Apartment Number
 City State ZIP Code
 Country (if outside U.S.)

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 City State ZIP Code
 Country (if outside U.S.)

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 Country (if outside U.S.)

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 City State ZIP Code
 Country (if outside U.S.)

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>
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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