

# 2016 Benefits Enrollment/Change Application



UNIVERSITY OF  
**NOTRE DAME**

OFFICE OF HUMAN RESOURCES

Postdoctoral Research Associate (PD), Research Associate, Sr. Research Associate, Teaching Scholar, Intern (IN),  
Visiting Faculty (VF)

CHANGE REASON:  New Hire  Marriage / Divorce  Newborn / Adoption  
 Loss of Coverage  Loss of Student Status  Other \_\_\_\_\_

EFFECTIVE DATE:

## EMPLOYEE INFORMATION

NAME   
NDID   
CAMPUS ADDRESS  Building  Room #  
CAMPUS PHONE (574) 631 -

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

MAILING ADDRESS  Street  Apt #  
 City  State  Zip code

MARITAL STATUS  Single  Married\*  Divorced  Widowed

\*Is your spouse currently employed at Notre Dame?  Yes  No

If yes, please provide your spouse's name: \_\_\_\_\_ spouse's DOB: \_\_\_\_\_

HOME PHONE

## Benefit Options (Monthly Deductions)

Medical, Dental, Vision Insurance and Flexible Spending  
Accounts are paid on a pre-tax basis.

### MEDICAL OPTION

APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

	INDIVIDUAL	INDIVIDUAL + 1	FAMILY
<b>MERITAIN PPO - CHOOSE LOCAL NETWORK</b>			
CHA NETWORK - MEMORIAL	MC <input type="radio"/> \$70.00	<input type="radio"/> \$187.00	<input type="radio"/> \$246.00
SELECT HEALTH NETWORK - ST. JOSEPH	MN <input type="radio"/> \$70.00	<input type="radio"/> \$187.00	<input type="radio"/> \$246.00
<b>MERITAIN HMO - CHOOSE LOCAL NETWORK</b>			
CHA NETWORK - MEMORIAL	MH <input type="radio"/> \$94.00	<input type="radio"/> \$236.00	<input type="radio"/> \$319.00
SELECT HEALTH NETWORK - ST. JOSEPH	MS <input type="radio"/> \$94.00	<input type="radio"/> \$236.00	<input type="radio"/> \$319.00
<b>MERITAIN HIGH DEDUCTIBLE HEALTH PLAN (HDHP)</b>			
CHA NETWORK - MEMORIAL	MX <input type="radio"/> \$26.00	<input type="radio"/> \$99.00	<input type="radio"/> \$114.00
SELECT HEALTH NETWORK - ST. JOSEPH	MZ <input type="radio"/> \$26.00	<input type="radio"/> \$99.00	<input type="radio"/> \$114.00
WAIVE MEDICAL COVERAGE FOR: (INCLUDE COPY OF INSURANCE CARD) <input type="radio"/> MYSELF <input type="radio"/> MY SPOUSE <input type="radio"/> MY DEPENDENT CHILD(REN)			
I AM COVERED MY SPOUSE WHO IS AN ND EMPLOYEE <input type="radio"/> ND <input checked="" type="radio"/> OR I AM COVERED OUTSIDE OF NOTRE DAME <input type="radio"/> O1 MY INSURANCE CARRIER IS: _____ (PLEASE ATTACH A COPY OF MEDICAL INSURANCE CARD)			

### DENTAL OPTION

APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

NOT PARTICIPATING

	INDIVIDUAL	INDIVIDUAL + 1	FAMILY
DELTA PREMIER, PPO	DD <input type="radio"/> \$16.74	<input type="radio"/> \$31.88	<input type="radio"/> \$56.78
DELTA PPO, POS	DP <input type="radio"/> \$20.50	<input type="radio"/> \$38.84	<input type="radio"/> \$71.48

### VISION OPTION

APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

NOT PARTICIPATING

	INDIVIDUAL	INDIVIDUAL + 1	FAMILY
EYEMED	VE <input type="radio"/> \$8.56	<input type="radio"/> \$16.16	<input type="radio"/> \$23.68

## Benefit Options (Monthly Deductions)

Accident, Critical Illness, and Life Insurance are paid on a post-tax basis.

### ACCIDENT INSURANCE

APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

NOT PARTICIPATING

	INDIVIDUAL	INDIVIDUAL + 1	FAMILY
ACCIDENT INSURANCE VP	<input type="radio"/> \$6.88	<input type="radio"/> \$12.04	<input type="radio"/> \$16.46

\*INDIVIDUAL COVERAGE IS INCLUDED AT NO COST WITH HIGH DEDUCTIBLE HEALTH PLAN (HDHP) ENROLLMENT.

### CRITICAL ILLNESS INSURANCE

APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

NOT PARTICIPATING

	INDIVIDUAL	INDIVIDUAL + 1	FAMILY
CRITICAL ILLNESS INSURANCE V#	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\*INDIVIDUAL COVERAGE IS INCLUDED AT NO COST WITH HIGH DEDUCTIBLE HEALTH PLAN (HDHP) ENROLLMENT.

RATES BASED UPON AGE AND CAN BE FOUND AT

[HTTP://HR.ND.EDU/BENEFITS/GROUP-INSURANCE/CRITICAL-ILLNESS-INSURANCE/](http://hr.nd.edu/benefits/group-insurance/critical-illness-insurance/)

# 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).

## LIFE INSURANCE BENEFICIARY DESIGNATIONS (REQUIRED FOR BASE LIFE AND TRAVEL ACCIDENT POLICIES)

Please designate at least one Primary Beneficiary for your \$25,000.00 (and any additional) Life Insurance Policy. This beneficiary designation also serves as your beneficiary designation for Travel Accident Insurance. \*Visiting Faculty are not eligible for Travel Accident Insurance.

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.)

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

NOT PARTICIPATING

SELF - SUPPLEMENTAL LIFE (1 - 10 TIMES) LS  \_\_\_\_\_ Option (1-10)

## DEPENDENT LIFE INSURANCE

\*APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

NOT PARTICIPATING

SPOUSE - \$12,500.00 LU01  \$5.64 CHILD(REN) - \$ 5,000.00 LC01  \$0.76

SPOUSE - \$25,000.00 LU02  \$11.30 CHILD(REN) - \$10,000.00 LC02  \$1.52

# Dependent Coverage Information

You are automatically eligible to utilize the Notre Dame Wellness Center even if you or your dependents are not electing benefits. Please complete the section below as the information is required to allow access.

List all eligible dependents.

RELATIONSHIP	FULL NAME	SSN *	BIRTH DATE	M/F	AGE 19 & OVER			PLEASE INDICATE Y/N					
					DISABLED †	Married#	FULL-TIME STUDENT ‡	MEDICAL	DENTAL ◊	VISION ◊	Accident	Critical Illness	
SELF													
SPOUSE													
DEPENDENT													
DEPENDENT													
DEPENDENT													
DEPENDENT													

\* Per IRS regulations, SSN is required if enrolling a dependent in a medical plan.

† 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 dental and vision insurance up to the age of 25.

## 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 insured under a group LTD insurance policy that provided income benefits for five years or more of a disability and was insured under the prior policy within three months preceding my UND benefit effective date.

Insurance company	Date Coverage Terminated	Initial
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## SUMMARY PLAN DESCRIPTION

I would like to receive my annual Summary Plan Descriptions, and any other applicable Department of Labor documents in the following manner (Please check box below).

Email  Postal Mail

I understand I am still able to request a printed Summary Plan Description free of charge, or request to be removed from the digital distribution list at any time in the future.

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 and supporting documentation (if applicable) must be submitted within 31 days of my benefit eligibility 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, OptumRx, 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 affects 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