2016 Benefits Enrollment/Change Application

UNIVERSITY OF NOTRE DAME
OFFICE OF HUMAN RESOURCES

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

ʊAPPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

		INDIVIDUAL	INDIVIDUAL + 1 ʊ	FAMILY ʊ
MERITAIN PPO - CHOOSE LOCAL NETWORK				
CHA NETWORK - MEMORIAL	MC	❍ $70.00	❍ $187.00	❍ $246.00
SELECT HEALTH NETWORK - ST. JOSEPH	MN	❍ $70.00	❍ $187.00	❍ $246.00
MERITAIN HMO - CHOOSE LOCAL NETWORK				
CHA NETWORK - MEMORIAL	MH	❍ $94.00	❍ $236.00	❍ $319.00
SELECT HEALTH NETWORK - ST. JOSEPH	MS	❍ $94.00	❍ $236.00	❍ $319.00
MERITAIN HIGH DEDUCTIBLE HEALTH PLAN (HDHP)				
CHA NETWORK - MEMORIAL	MX	❍ $26.00	❍ $99.00	❍ $114.00
SELECT HEALTH NETWORK - ST. JOSEPH	MZ	❍ $26.00	❍ $99.00	❍ $114.00

WAIVE MEDICAL COVERAGE FOR: (INCLUDE COPY OF INSURANCE CARD) ❍ MYSELF ❍ MY SPOUSE ❍ MY DEPENEDENT CHILD(REN)

I AM COVERED MY SPOUSE WHO IS AN ND EMPLOYEE ❍ ND **OR** I AM COVERED OUTSIDE OF NOTRE DAME ❍ O1 MY INSURANCE CARRIER IS: _____ (PLEASE ATTACH A COPY OF MEDICAL INSURANCE CARD)

DENTAL OPTION

ʊAPPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION ❑ NOT PARTICIPATING

		INDIVIDUAL	INDIVIDUAL + 1 ʊ	FAMILY ʊ
DELTA PREMIER, PPO	DD	❍ $16.74	❍ $31.88	❍ $56.78
DELTA PPO, POS	DP	❍ $20.50	❍ $38.84	❍ $71.48

VISION OPTION

ʊAPPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION ❑ NOT PARTICIPATING

		INDIVIDUAL	INDIVIDUAL + 1 ʊ	FAMILY ʊ
EYEMED	VE	❍ $8.56	❍ $16.16	❍$23.68

FLEXIBLE SPENDING ACCOUNTS (ENTER YOUR MONTHLY ELECTION) ❑ NOT PARTICIPATING

Health Care Account (Minimum $10.00 per month, Maximum $2,550.00 per year per employee) FMC ❍ _____Monthly 2016 Election

Dependent Care Account (Minimum $10.00 per month, Maximum $5,000.00 per year per family) FDC ❍ _____Monthly 2016 Election

Benefit Options (Monthly Deductions)

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

ACCIDENT INSURANCE

ʊAPPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION ❑ NOT PARTICIPATING

		INDIVIDUAL	INDIVIDUAL + 1 ʊ	FAMILY ʊ
ACCIDENT INSURANCE	VP	❍ $6.88	❍ $12.04	❍ $16.46

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

CRITICAL ILLNESS INSURANCE

ʊAPPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION ❑ NOT PARTICIPATING

CRITICAL ILLNESS INSURANCE V# ❍ INDIVIDUAL ❍ INDIVIDUAL + 1 ʊ ❍ FAMILY ʊ

*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/

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.

PRIMARY BENEFICIARY

RELATIONSHIP

PERCENTAGE

ADDRESS *Street* *Apt #*

City *State* *Zip code*

Country (if outside U.S.)

PRIMARY BENEFICIARY

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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.

					AGE 19 & OVER			PLEASE INDICATE Y/N				
RELATIONSHIP	**FULL NAME**	**SSN ***	**BIRTH DATE**	**M/F**	**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*

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** _____