UNIVERSITY OF NOTRE DAME
OFFICE OF HUMAN RESOURCES

2016 Benefits Enrollment/Change Application

Research Visitor (VS)/Visiting Scholar (VS) on a J1 Visa

DATE OF HIRE: _____ **EFFECTIVE DATE:** _____

EMPLOYEE INFORMATION

NAME _____

NDID/NET ID _____

CAMPUS ADDRESS Building _____ Room # _____

CAMPUS PHONE (574) 631 - ____

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 ADDRESS Street _____ Apt # _____

City _____ State _____ Zip code _____

Country (if outside U.S.) _____

MAILING ADDRESS Street _____ Apt # _____

City _____ State _____ Zip code _____

HOME PHONE _____

Benefit Options (Monthly Deductions)

MEDICAL OPTION

❶APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

		INDIVIDUAL	INDIVIDUAL + 1 ❶	FAMILY ❶
MERITAIN PPO - CHOOSE LOCAL NETWORK				
CHA NETWORK - MEMORIAL	MC	❍ $632.00	❍ $1,264.00	❍ $1,896.00
SELECT HEALTH NETWORK - ST. JOSEPH	MN	❍ $632.00	❍ $1,264.00	❍ $1,896.00
MERITAIN HMO - CHOOSE LOCAL NETWORK				
CHA NETWORK - MEMORIAL	MH	❍ $656.00	❍ $1,313.00	❍ $1,969.00
SELECT HEALTH NETWORK - ST. JOSEPH	MS	❍ $656.00	❍ $1,313.00	❍ $1,969.00

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

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 ◇
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.

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** _____