UNIVERSITY OF NOTRE DAME
OFFICE OF HUMAN RESOURCES

2015 Benefits Change Application

CHANGE REASON: ☐ Newborn/Adoption ☐ Marriage ☐ Divorce ☐ Loss of Coverage ☐ Loss of Student Status ☐ Other _____

EFFECTIVE DATE OF CHANGE : _____

EMPLOYEE INFORMATION

NAME _____

NDID/NET ID _____

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: _____

EMERGENCY CONTACT INFORMATION

IN EVENT OF EMERGENCY:

NAME _____

RELATIONSHIP _____

PHONE _____

HOME ADDRESS _____ *Street* *Apt. #*

City *State* *Zip code*

Country (if outside U.S.)

Benefits Options (Monthly Deductions)

All benefit deductions are paid on a pre-tax basis.

MEDICAL OPTION

❍APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

		INDIVIDUAL	INDIVIDUAL + 1 ❍	FAMILY ❍
MERITAIN PPO—CHOOSE LOCAL NETWORK				
CHA NETWORK—MEMORIAL	MC	❍ $86.00	❍ $222.00	❍ $302.00
SELECT HEALTH NETWORK—ST. JOSEPH	MN	❍ $86.00	❍ $222.00	❍ $302.00
MERITAIN CHA HMO (MEMORIAL)	MH	❍ $95.00	❍ $251.00	❍ $336.00
MERITAIN SELECT HMO (ST. JOSEPH)	MS	❍ $71.00	❍ $201.00	❍ $252.00

WAIVE MEDICAL COVERAGE FOR: ❍ MYSELF ❍ MY SPOUSE ❍ MY DEPENDENT 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

❍APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

		INDIVIDUAL	INDIVIDUAL + 1 ❍	FAMILY ❍
DELTA PREMIER, PPO	DD	❍ $16.02	❍ $30.26	❍ $52.60
DELTA PPO, POS	DP	❍ $20.68	❍ $37.00	❍ $66.32

WAIVE DENTAL COVERAGE FOR: ❍ MYSELF ❍ MY SPOUSE ❍ MY DEPENDENT CHILD(REN)

VISION OPTION

❍APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

		INDIVIDUAL	INDIVIDUAL + 1 ❍	FAMILY ❍
EYE MED	VE	❍ $8.56	❍ $16.16	❍ $23.68

WAIVE VISION COVERAGE FOR: ❍ MYSELF ❍ MY SPOUSE ❍ MY DEPENDENT CHILD(REN)

FLEXIBLE SPENDING ACCOUNTS (ENTER YOUR MONTHLY ELECTION)

❑ NOT PARTICIPATING

Health Care Account (Minimum $10.00 per month, Maximum $2,500.00 per employee per year) FMC ❍ _____ Monthly 2015 Election

Dependent Care Account (Minimum $10.00 per month, Maximum $5,000.00 per family per year) FDC ❍ _____ Monthly 2015 Election

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 only the dependent(s) affected by the change(s).

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

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

✧ 12 credit hours or more for dependents age 19 – 25

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

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

\# Married and unmarried children up to the age of 26 are eligible for medical 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
RELATIONSHIP
PERCENTAGE

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

❑ 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

❍ APPLICABLE DEPENDENT VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

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 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****,* ***ESI****,* ***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 _____