



Benefits Program Enrollment and Change Form

(Department use only)

Employee Must Complete in Full (Please print or type). Return form to the Human Resources Department.

EMPLOYEE INFORMATION: [] New Enrollment [] Open Enrollment Change [] Life Status Change [] Address Change

Name: _____ Social Security #: _____
Home Address: _____ Marital Status: [] Single [] Married
City, State, Zip: _____ [] Divorced [] Widowed
Department: _____ Date of Hire: _____ Employment [] Faculty [] Staff
Date of Birth: _____ Work Phone# _____ Status: [] Union [] COBRA
Home Phone# _____ [] LTD [] Early Retiree
[] WC [] Provincial
Sex: [] Male [] Female

BENEFIT CHOICES:

Medical Insurance (Check One)
[] NO COVERAGE
(Must attach proof of coverage)
[] Keystone Flex HMO
\$10 Primary Care Physician Co-pay
\$20 Specialist Co-pay
[] Keystone Direct Point of Service (POS)
\$15 Primary Care Physician Co-pay
\$20 Specialist Co-pay
[] Personal Choice Flex PPO
\$15 General Office Visit Co-pay
\$25 Specialist Co-pay
Type of Coverage (Check One)
[] Single
[] Employee & Spouse
[] Employee & Child
[] Employee & Children
[] Family
Dental Insurance
Delta Dental USA - Group 2257
[] NO COVERAGE*
*Two year waiting period before re-enrollment is allowed.
Type of Coverage (Check One)
[] Single
[] Two Persons
[] Three or More Persons
Supplemental Life:
[] Yes [] No [] No Change
If yes then:
Smoker [] Yes [] No
May be eligible for \$10,000 up to \$300,000 (\$10,000 increments only)
Increase \$ _____
Decrease \$ _____
Total Amount Requested \$ _____
Dependent Life:
Spouse Benefit \$ 25,000
Child Benefit \$ 5,000
[] Yes [] No [] No Change

For your payroll deduction please review employee contribution on the benefit rate sheet.

Membership Information: Please provide requested information for self and each dependent you wish to cover. Write "Yes" or "No" in the boxes to indicate if a dependent is to be covered under each benefit plan. If you are enrolling in the HMO or the POS plan, select a Primary Care Physician for each person. The University reserves the right to verify eligibility of all dependents.

Table with 8 columns: Full Name Last, First, MI; Social Security #; Sex (M/F); DOB M/D/Y; Relation Code*; Yes or No for each Person Medical / Dental; Primary Physician ID Number; Primary Physician Name. Rows include (Employee), (Spouse), (Child), (Child), (Child), (Child).

*E=Employee S=Spouse C=Child F=Full-Time Student Dependent D=Disabled

Please make a copy of this form for your records.

(over)

Coordination of Benefits: Complete this section if you and/or your spouse/dependents are covered by any other Medical/Dental Insurance.

Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate name and address of employer. Company Name: Address: City, State, Zip Code	Is your spouse covered by any other Health or Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If other insurance, please indicate name and policy #. Insurance Plan: _____ Policy #: _____ Who is covered by this policy? <input type="checkbox"/> You <input type="checkbox"/> You & Spouse <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Family
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Dependent Information: Do any of your dependents live at another address? Yes No

If yes, who and at what address? _____

Explain the circumstances _____

Life Insurance

Your Beneficiaries: Please indicate who should receive benefits under the Employee Life Insurance in the event of your death. You also can assign a percentage of benefits to each beneficiary, but the total must add to 100%. **By completing this section for life insurance, you are establishing a NEW beneficiary election for both your Basic and Supplemental life coverages.**

PRIMARY BENEFICIARY

Name	Relation	Social Security	Percentage

CONTINGENT BENEFICIARY

Name	Relation	Social Security	Percentage

Declaration

I elect coverage under the plans specified on this application for the person(s) listed and agree to abide by the conditions of the agreement and pay required premiums for the plans selected. I and my listed eligible dependent(s) authorize any hospital, physician or other healthcare provider to furnish Independence Blue Cross and Highmark Blue Shield as applicable, its assignee or designee, with such medical information about the applicant and dependent(s) listed on the applications of Independence Blue Cross and Highmark Blue Shield, as applicable, may require for claim payment utilization review, quality assurance or in fulfillment of obligations imposed by applicable state or federal law. I understand that my coverage(s) will become effective upon the approval of my application. I understand and agree that; (1) the agreement may contain certain waiting periods; (2) coverage is subject to the terms and conditions of the applicable group health agreement which in the case of HMO coverage provides, except for emergencies, all medical cases must be initiated by the primary care physician selected by the member; (3) the agreement(s) shall be binding on Independence Blue Cross, Highmark Blue Shield, American General and all the Insurance Providers as applicable, whose plans are contained herein only if all my statements are complete and true.

Notice Regarding Fraudulent Information:

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading information concerning any facts material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee's Agreement

I request to arrange for the above coverage and direct the University to deduct any required contributions from my regular pay. I understand that Supplemental Life Insurance contributions are made on an after-tax basis. I understand when the open enrollment period ends, my election will become irrevocable for the entire plan year unless there is a change in my family status as described in the open enrollment brochure.

I choose to make my Medical and/or Dental contributions on a (choose one)	<input type="checkbox"/> pre-tax	<input type="checkbox"/> after-tax basis.
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Employee Signature: _____ **Date:** _____

Employer Signature: _____ **Date:** _____

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