## Benefits Enrollment Form

### PART A
- **Legal Marital Status:**
  - [ ] Married
  - [ ] Not Married
- **Sex:**
  - [ ] Male
  - [ ] Female
- **Date of Birth:**
- **Employment Date:**

### PART B
**MEDICAL INSURANCE COVERAGE**
- [ ] Traditional PPO
- [ ] Deductible PPO
- [ ] HMO Name
- [ ] I Decline Coverage

Please choose one of the following:
- [ ] Employee Only
- [ ] Employee & Child(ren)
- [ ] Employee & Family
- [ ] Employee & Spouse or Domestic Partner

### PART C
**DENTAL COVERAGE**
- [ ] Employee Only
- [ ] Family
- [ ] I Decline Coverage

**VISION COVERAGE**
- [ ] Employee Only
- [ ] Family
- [ ] I Decline Coverage

### PART D
**DEPENDENTS – COMPLETE IN FULL – LIST ANY ADDITIONAL DEPENDENTS ON BACK OF THIS FORM**

<table>
<thead>
<tr>
<th>ADD</th>
<th>DELETE</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>GENDER</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>DATE OF BIRTH</th>
<th>RELATIONSHIP</th>
<th>TYPE OF COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical</td>
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<td></td>
<td></td>
<td></td>
<td>Dental</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Vision</td>
</tr>
</tbody>
</table>

**PART E**
**BENEFICIARY DESIGNATION – BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

<table>
<thead>
<tr>
<th>NAME</th>
<th>PERCENT</th>
<th>RELATIONSHIP</th>
<th>DATE OF BIRTH</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*IMPORTANT: Please list your beneficiaries for your Basic Life and AD&D insurance. List additional beneficiaries on back of this form. Benefit is payable to contingent beneficiary ONLY if all primary beneficiaries are deceased. (If a class of beneficiaries contains more than one person, the benefit is apportioned equally unless specified otherwise.)*

### PART F
**OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**
- [ ] I Elect Coverage
- [ ] I Decline Coverage

List additional beneficiaries on back of this form. Beneficiaries will be the same as for Basic Life (Part E), unless you list different beneficiaries on the back of this form.

### PART G
**DEPENDENT OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**
- [ ] I Elect Coverage (Additional form required)
- [ ] I Decline Coverage

### PART H
**MEDICAL INSURANCE PLAN CHANGE**
- [ ] Date of change:

**DEPENDENT COVERAGE CHANGES**
- [ ] Date of change:

<table>
<thead>
<tr>
<th>Reason for change</th>
<th>Type of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td></td>
</tr>
<tr>
<td>Spouse's coverage terminated</td>
<td></td>
</tr>
<tr>
<td>Child reached age limit</td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td></td>
</tr>
<tr>
<td>No longer a student</td>
<td></td>
</tr>
<tr>
<td>Birth/Adoption</td>
<td></td>
</tr>
</tbody>
</table>

### PART I
- I hereby authorize deductions from my salary of the amount required, if any, for the insurance indicated. This authorization will be in effect until revoked in writing. Medical and dental insurance deduction is paid on a pre-tax basis unless a waiver form is submitted. (See Benefits Handbook for pre-tax medical insurance deduction information.)

<table>
<thead>
<tr>
<th>EMPLOYEE SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

### Additional Fields
- Health Effective Date
- Dental Effective Date
- Vision Effective Date
- Basic Life/AD&D Effective Date
- Optional Life/AD&D Effective Date
- NYS DBL Effective Date
- LTD Effective Date
- Campus Location