



- New Enrollment** (Waiting periods apply. Please refer to *Benefits Handbook*.)
- Late Enrollment** (Please refer to *Benefits Handbook* for rules on late enrollment.)
- Open Enrollment** (Waiting periods apply. Please refer to *Benefits Handbook*.)

- Change:** **Coverage** (Complete Parts A, B, C, D, F, G, H, I)
- Health Plan** (Complete Parts A, B, D, H, I)
- Name** (Complete Parts A, I)
- Life Insurance Beneficiary** (Complete Parts A, E, F, I)
- Optional Life Insurance** (Complete Parts A, F, I)

Benefits Enrollment Form

PART A Legal Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Not Married		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:		Employment Date:	
Name: LAST FIRST MI		FORMER LAST NAME (IF CHANGED)		SOCIAL SECURITY NUMBER			
Address: STREET OR P.O. BOX CITY STATE ZIP CODE		TELEPHONE ()		E-MAIL ADDRESS			

PART B MEDICAL INSURANCE COVERAGE Traditional PPO Deductible PPO HMO Name (Additional form required): I Decline Coverage

Please choose one of the following:
 Employee Only **Employee & Child(ren)** **Employee & Family** **Employee & Spouse or Domestic Partner** (Requires additional documentation and approval)

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

ADD	DELETE	LAST NAME	FIRST NAME	MI	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	TYPE OF COVERAGE
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

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

NAME	PERCENT	RELATIONSHIP	DATE OF BIRTH	ADDRESS	BENEFICIARY DESIGNATION
					Primary–Class 1 <input type="checkbox"/> Primary <input type="checkbox"/> Contingent <input type="checkbox"/> Contingent
					Contingent–Class 2 <input type="checkbox"/> Primary <input type="checkbox"/> Contingent
					<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

***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
Employee Paid – Submit within 60 days of hire or medical statement required Multiple of earnings 1X 2X 3X 4X 5X 6X 7X

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 | **OPTIONAL SUPPLEMENTAL SHORT-TERM DISABILITY INSURANCE** I Elect Coverage (Additional form required) I Decline Coverage

PART H MEDICAL INSURANCE PLAN CHANGE Date of change: _____

<input type="checkbox"/> Open Enrollment From: <input type="checkbox"/> Traditional PPO <input type="checkbox"/> Deductible PPO <input type="checkbox"/> HMO Plan _____ <input type="checkbox"/> Decline Coverage <input type="checkbox"/> Other _____ <input type="checkbox"/> Moving out of area	To: <input type="checkbox"/> Traditional PPO <input type="checkbox"/> Deductible PPO <input type="checkbox"/> HMO Plan _____ <input type="checkbox"/> Decline Coverage <input type="checkbox"/> Other _____
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DEPENDENT COVERAGE CHANGES Date of change: _____

Reason for change:

<input type="checkbox"/> Marriage	<input type="checkbox"/> Newly eligible for coverage	<input type="checkbox"/> Dependent died
<input type="checkbox"/> Spouse's coverage terminated	<input type="checkbox"/> Child reached age limit	<input type="checkbox"/> Divorce
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> No longer a student	<input type="checkbox"/> Birth/Adoption

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.)

EMPLOYEE SIGNATURE _____ DATE _____

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
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