



- 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- POSTDOCTORAL EMPLOYEE

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:	
LAST		FIRST		MI		FORMER LAST NAME (IF CHANGED)	
Name:		SOCIAL SECURITY NUMBER					
STREET OR P.O. BOX		CITY		STATE		ZIP CODE	
Address:		TELEPHONE ()				E-MAIL ADDRESS	

PART B MEDICAL INSURANCE COVERAGE <input type="checkbox"/> Traditional PPO <input type="checkbox"/> Deductible PPO <input type="checkbox"/> HMO Name (Additional form required):		<input type="checkbox"/> UMR Health Plan <input type="checkbox"/> I Decline Coverage	
Please choose one of the following if electing Traditional PPO, Deductible PPO or HMO plan:		Please choose one of the following if electing UMR Health plan:	
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Family <input type="checkbox"/> Employee & Spouse or Domestic Partner <small>(Requires additional documentation and approval)</small>		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Employee & Family	

PART C DENTAL COVERAGE <input type="checkbox"/> Employee Only <input type="checkbox"/> Family <input type="checkbox"/> I Decline Coverage		VISION PLAN <input type="checkbox"/> Regular <input type="checkbox"/> Plus <input type="checkbox"/> I Decline		Choose One: <input type="checkbox"/> Employee Only <input type="checkbox"/> Family	
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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*					BENEFICIARY DESIGNATION	
NAME	PERCENT	RELATIONSHIP	DATE OF BIRTH	ADDRESS	Primary–Class 1	Contingent–Class 2
					<input type="checkbox"/> Primary	<input type="checkbox"/> Contingent
					<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		<input type="checkbox"/> I Elect Coverage <input type="checkbox"/> I Decline Coverage	
Employee Paid – Submit within 60 days of hire or medical statement required		Multiple of earnings <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> 5X <input type="checkbox"/> 6X <input type="checkbox"/> 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		OPTIONAL SUPPLEMENTAL SHORT-TERM DISABILITY INSURANCE	
<input type="checkbox"/> I Elect Coverage (Additional form required) <input type="checkbox"/> I Decline Coverage		<input type="checkbox"/> I Elect Coverage (Additional form required) <input type="checkbox"/> I Decline Coverage	

PART H MEDICAL INSURANCE PLAN CHANGE Date of change:		DEPENDENT COVERAGE CHANGES Date of change:	
<input type="checkbox"/> Open Enrollment From: <input type="checkbox"/> Traditional PPO To: <input type="checkbox"/> Traditional PPO <input type="checkbox"/> Moving out of area <input type="checkbox"/> Deductible PPO <input type="checkbox"/> Deductible PPO <input type="checkbox"/> HMO Plan <input type="checkbox"/> HMO Plan <input type="checkbox"/> Decline Coverage <input type="checkbox"/> Decline Coverage <input type="checkbox"/> UMR Health Plan <input type="checkbox"/> UMR Health Plan		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, dental, and vision 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
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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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