SUNY RF

☐ **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: ☐ Married ☐ Not Married | Sex: ☐ Male ☐ Female | Date of Birth: | | | Employment Date: | |

Name: (LAST / FIRST / MI) | FORMER LAST NAME (IF CHANGED) | EMPLOYEE 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): ☐ UMR Health Plan ☐ I Decline Coverage

Please choose one of the following if electing Traditional PPO, Deductible PPO or HMO plan:
☐ **Employee Only** ☐ **Employee & Child(ren)** ☐ **Employee & Family** ☐ **Employee & Spouse or Domestic Partner** (Requires additional documentation and approval)

Please choose one of the following if electing UMR Health plan :
☐ **Employee Only** ☐ **Employee + One** ☐ **Employee & Family**

PART C **DENTAL COVERAGE** ☐ Employee Only ☐ Family ☐ I Decline Coverage | **VISION PLAN** ☐ Regular ☐ Plus ☐ I Decline | **Choose One**: ☐ Employee Only ☐ Family

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
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ Vision
☐	☐								☐ Medical ☐ Dental ☐ 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	Contingent–Class 2
					☐ Primary	☐ Contingent
					☐ Primary	☐ Contingent
					☐ Primary	☐ 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: | | |

☐ Open Enrollment
☐ Moving out of area

From: ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Plan _____ ☐ Decline Coverage ☐ UMR Health Plan

To: ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Plan _____ ☐ Decline Coverage ☐ UMR Health Plan

DEPENDENT COVERAGE CHANGES Date of change: | | |

Reason for change:
☐ Marriage ☐ Newly eligible for coverage ☐ Dependent died
☐ Spouse's coverage terminated ☐ Child reached age limit ☐ Divorce
☐ Other, specify _____ ☐ No longer a student ☐ 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

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