



## Benefits Enrollment/Change Form

Please fill out the form completely and return with all required documentation (*marriage license, birth certificates etc.*) to the following address within 31 days of your Hire/Benefits Eligible Date or Change In Status Date to:

University of Chicago Human Resource Management-Benefits Office  
6054 S. Drexel Avenue  
Chicago, IL 60637

(Please Print and use **BLACK INK ONLY**)

### Employee Information

Name: Last, First Name, Middle Initial		Hire Date	Effective Date
SS #	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
Address, City, State, Zip			
Home Phone	Work Phone	Department Name	
Work e-mail	<input type="checkbox"/> New Employee <input type="checkbox"/> Current Employee	<input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Adding Dependents	<input type="checkbox"/> Drop Dependents <input type="checkbox"/> Termination <input type="checkbox"/> Cancel Coverage

### Select Medical Plan

I want to be covered by the following Medical Plan: (Check one box)

- Maroon Plan (BCBS IL PPO)                       HMO Illinois (BCBS IL HMO)  
 University of Chicago Health Plan (UCHP)                       Humana Premier HMO  
 I want to waive Medical Coverage (I certify that I currently have other Medical Coverage)

Select the level of Coverage you want below: (Check one box)

- Yourself                       Yourself + One Dependent                       Family

### Select Dental Plan

I want to be covered by the following Dental Plan (Check one box)

- MetLife Dental Co-Pay Plan                       MetLife Dental PPO Plan  
 I want to waive Dental Coverage

Select the level of Coverage you want below: (Check one box)

- Yourself                       Yourself + One Dependent                       Family

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**Benefits Enrollment/Change Form**

SS# \_\_\_\_\_

**Employee/Dependent Coverage**

If you enroll in *UCHP* select physician or *PCG*, *HMO-IL* select Medical Group Name+ Group I.D. number, *Humana* select Physician + I.D.# Each Dependent may select a different contracting Medical Group/Physician.

Relationship	Name (Last, [if different], First MI)	Date of Birth MM/DD/YY	SS #	HMO Medical Group Name and I.D. # or Physician's Name & I.D.#	Medical	Dental
<input type="checkbox"/> Employee (Only Medical Group Name and number in space to the right)						
<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> U of C Registered Domestic Partner <input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Other Insurance Information**

Do you or any of your family members have OTHER GROUP MEDICAL COVERAGE?  Yes  No

Employed By: \_\_\_\_\_ Insured's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Group Number: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

The other insurance is for :  Yourself  Yourself + One Dependent  Family

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### Group Life Insurance

The University provides you with \$12,000 in Basic Life Insurance coverage for full-time employees, \$6,000 if part-time. Select the amount of Supplemental Life Insurance you want below. If you do not elect Supplemental Coverage within 31 days of your eligibility date and later wish to add additional coverage, you must complete the Unum Provident Evidence of Insurability Form and submit it to Unum. If your Supplemental Insurance is more than \$ 600,000, you must complete an "Evidence of Insurability Form" for the incremental amount over \$ 600,000. The portion of coverage over \$ 600,000 takes effect on the Insurance Company's approval date. The Group Insurance carrier will review and must approve the application before coverage goes into effect.

#### Supplemental Life:

- Option 1: 1X Annual Salary (Including University-paid amount)
- Option 2: 2X Annual Salary (Including University-paid amount)
- Option 3: 3X Annual Salary (Including University-paid amount)
- Option 4: 4X Annual Salary (Including University-paid amount)
- I do not wish to participate in Supplemental Life

### Long Term Disability

Union and Confidential Employees cannot postpone enrollment

**If you elect to waive coverage now and enroll at a later date you must complete the Unum Provident Evidence of Insurability Form and submit it to Unum Insurance Company.**

The group insurance carrier will review and/either approve/decline the application before the coverage would go into effect. When enrolled mandatorily into the LTD program based on Retirement Plan requirements, you are enrolled in the BASIC PLAN.

#### LTD PLAN SELECTION: (Please mark an "x" in the appropriate space)

- I elect to participate in the Basic Plan
- I elect to participate in the Optional Plan
- I postpone participation to a later date, but no later than the basic Retirement Plan enrollment date.
- I am age 65 or older and I elect to waive participation

### Personal Accident Insurance

- I wish to participate in the Personal Accident Plan.**

Please indicate the amount of coverage. This amount must be in increments of \$10,000 with a minimum of \$20,000 and a maximum of \$500,000

\$

Select the Coverage Level:  Yourself Only  Yourself and Family

- I do not wish to participate in the Personal Accident Plan**

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**Life/Personal Accident Beneficiaries**

I designate the following beneficiary (ies) for Life and Personal Accident Insurance Coverage: *(If necessary use an additional page)*

Name	Relationship	SS#	Designated Percentage (%)
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**Primary**

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*Will receive the benefit only if Primary beneficiary (ies) are deceased.*

**Contingent**

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**Flexible Spending Accounts**

**Please note:** Your election is binding until the end of the calendar year. You will have until March 15<sup>th</sup> of the following year to use your account balance before it is forfeited. Expenses/claims must be incurred during the time that you participate in the plan in order to be eligible for reimbursement.

- I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs.
- I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize the University of Chicago to make pretax deductions from my salary on a monthly/bi-weekly basis.

The amount you can contribute to each FSA is limited. The minimum amount you can contribute is \$250 and the annual maximum amount is \$5,000.

\*If you are a Highly Compensated Employee, your Dependent Care contribution is limited to a lower amount. Contact the Benefits Office at [benefits@uchicago.edu](mailto:benefits@uchicago.edu) regarding this lower limit.

**Health Care Annual Election**

\$\_\_\_\_\_ (Minimum annual election is \$250)  
 Health Care Flexible Spending Account is for health care expenses incurred by yourself and your dependents.  
 Request for change in status \_\_\_\_\_ New HC Annual election \_\_\_\_\_

**Dependent Care Annual Election**

\$\_\_\_\_\_   
 Dependent Care Flexible Spending Account is for care of your Dependents under age 13, while you are at work.  
 Request for change in status \_\_\_\_\_ New DC Annual election \_\_\_\_\_

**Pay schedule (Circle): Biweekly or Monthly**

**\*Annual election will be divided equally based on each pay period.\***

**BENEFITS OFFICE ONLY**

**Per Pay Period Deduction**

\$ \_\_\_\_\_

\$ \_\_\_\_\_

**First payday from which a deduction will be made: \_\_\_/\_\_\_/\_\_\_**

**Effective Date of Coverage: \_\_\_\_\_**

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**Signature/Authorization (sign and date below)**

Please attach all required documentation to forms (marriage license, birth certificates etc.).  
Sign, date, and return to the BENEFITS OFFICE at the address on page 1.

**By signature below I certify that:**

I hereby apply for participation in my employer’s benefits plan (s) for those benefits for which I am or may become eligible under the terms and conditions of said plan and any present or future amendments thereto, and subject to acceptance of my enrollment. I hereby authorize my employer to deduct from my earnings the required contributions, if any, toward the cost of this plan (s).

- I understand that I cannot change any of the elections for medical, dental, dependent coverage and Flexible Spending Accounts until the next open enrollment period, unless I have a qualifying change in status. Deductions for these plans will be taken on a pre-tax basis
- If I waived medical coverage, I certify that I have other medical coverage
- I understand the effect of any pre-tax contributions on my pay.

I authorize the release to and use by the claims processor of any medical information necessary to establish the validity of any claim for benefits for myself or on behalf of my eligible dependents. This authorization shall remain valid from the date signed through the term of coverage of the program. A copy of this authorization shall be as valid as the original. I certify that I have read the provisions hereof which are hereby incorporated in and made a part of this form.

\_\_\_\_\_  
Employee Name (Please Print)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date