



Ave Maria University Benefit Enrollment or Change Form

Employee Last name, First name, Middle Initial: _____

Date of Hire: _____ Gender: Male Female Date of Birth (month/day/year): _____

Street Address: _____ Apt#: _____ City: _____ State: _____ Zip _____

Country: _____ Phone: _____ Social Security: _____

Marital Status: Single Married Divorced Widowed Separated

Salary: \$ _____ Job Title: _____

Change Reason: Birth of Child Marriage Divorce Change in Spouse Coverage
(Please provide evidence of the qualifying event change reason.)

HealthSmart (Medical):

Employee Health Coverage: Employee Only Employee & Spouse Employee & Child(ren) Family

HealthSmart Plans:	Select a Plan:
Buy-Up 500	<input type="radio"/>
Core 1000	<input type="radio"/>
HDHP 1300	<input type="radio"/>

01 am refusing all Health Coverage at this time. I understand that if I decide to apply at a later date, coverage will not be available until the next open or special enrollment period without a qualifying family status change,

You must supply proof of insurance to Human Resources if you want to obtain the opt out stipend

Signature: _____ Date: _____

2017 Annual Medical Flexible Spending Account Amount: _____ (Maximum \$2,550 Annual)

2017 Annual Dependent Care Flexible Spending Account: _____ (Maximum \$5,000 Annual)

Please note: if you elect to fund a Health Savings Account, you cannot also participate in a Medical FSA

I am refusing enrollment in either a Medical or Dependent Care Flexible Spending Account at this time.

Signature: _____ Date: _____

Delta Dental Insurance:

Employee Dental Coverage: Employee Only Employee & Spouse Employee & Child(ren) Family

Delta Dental High PPO Plan	<input type="radio"/>
Delta Dental Low DHMO Plan	<input type="radio"/>
	<input type="radio"/>

0 I am refusing all Dental Coverage at this time. I understand that if I decide to apply at a later date, coverage will not be available until the next open or special enrollment period without a qualifying family status change.

You must supply proof of insurance to Human Resources if you want to obtain the opt out stipend

Signature: _____ Date: _____

VSP (Vision):

Employee Vision Coverage: Employee Only Employee & Spouse Employee & Child(ren) Family

I am refusing all Vision Coverage at this time. I understand that if I decide to apply at a later date, coverage will not be available until the next open or special enrollment period without a qualifying family status change.

Signature: _____ Date: _____

Enrollment Form 2016-2017

AllState Critical Illness Plan: Employee EE & Children Employee & Spouse Employee + Family

I am refusing all Critical Illness Coverage at this time. I understand that if I decide to apply at a later date, coverage will not be available until the next open or special enrollment period without a qualifying family status change.

Signature: _____ Date: _____

AllState Accident Plan: Employee Only Employee & Spouse Employee & Child(ren) Family

I am refusing all Accident Coverage at this time. I understand that if I decide to apply at a later date, coverage will not be available until the next open or special enrollment period without a qualifying family status change.

Signature: _____ Date: _____

AllState Indemnity Medical Plan: Low Policy _____ High Policy _____
 Employee Only Employee & Spouse Employee & Child(ren) Family

I am refusing all Indemnity Medical Coverage at this time. I understand that if I decide to apply at a later date, coverage will not be available until the next open or special enrollment period without a qualifying family status change.

Signature: _____ Date: _____

Dependent Information: If you need additional spaces, please provide on another sheet.

If your dependents are the same as your current enrollment, please write SAME in the box below

Dependent Last Name	Dependents First Name	Social Security Number	Sex	Date of Birth <i>mmlddlyyyy</i>	Relation to you	Check if Disabled	Medical	Dental	Vision
			OM OF	/ /	<input type="radio"/> Spouse <input type="radio"/> Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			OM OF	/ /	<input type="radio"/> Spouse <input type="radio"/> Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			OM OF	/ /	<input type="radio"/> Spouse <input type="radio"/> Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			OM OF	/ /	<input type="radio"/> Spouse <input type="radio"/> Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			OM OF	/ /	<input type="radio"/> Spouse <input type="radio"/> Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			OM OF	/ /	<input type="radio"/> Spouse <input type="radio"/> Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

			OM OF	/ /	O Spouse O Child	0	0	0	0
			OM OF	/ /	O Spouse O Child	0	0	0	0
			OM OF	/ /	O Spouse O Child	0	0	0	0
			OM OF	/ /	O Spouse O Child	0	0	0	0
			OM OF	/ /	O Spouse O Child	00	00	00	00
			OM OF	/ /	O Spouse O Child	0	0	0	0

Agreement to Save Taxes on Insurance Premiums

- YES - I have enrolled in certain employer-sponsored insurance benefits. I understand that my share of the premium for these benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.
- NO- I decline to have my benefit premiums paid with pre-tax dollars, and want them paid with after tax dollars and understand that I will lose all tax savings I could receive as a participant.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature: _____ Date: _____

- Please complete and email your completed form to HR@avemaria.edu
- If you have any benefit plan questions, please do not hesitate to call Human Resources at Ave Maria University: 239-304-7074 or 280-2563