Ave Maria University Benefit Enrollment or Change Form

Employee Last name, First name, Middle Initial:_____

Date of Hire:_____**Gender:** 0 Male 0 Female **Date of** Birth (month/day/year):_____

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

Country:_____**Phone:**_____**Social Security:**_____

Marital Status: 0 Single O Married O Divorced O Widowed O Separated

Salary:$_____**Job Title:**_____

Change Reason: _____Birth of Child _____Marriage _____Divorce ____Change in Spouse Coverage

(Please provide evidence of the qualifying event change reason.)

UMR (Medical):

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

UMR Plans:	Select a Plan:
Buy-Up 500	0
Core 1000	0
HDHP 1300	0

0 I 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:_____

2019-20 Annual Medical Flexible Spending Account $_____ **(Maximum $2,700.00)**

2019-20 Annual DependentCareFlexible Spending $_____ (Maximum $5,000)
Account:

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: _____

MetLife Dental Insurance:

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

MetLife High Dental PPO Plan	
MetLife Low PPO Plan	

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): _____High Vision Plan _____ Low Base Vision Plan

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

0 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: D Employee D EE &Children D Employee & Spouse D Employee + Family

0 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: _____

Note; if you waive this at hire and decide to enroll later, it will be subject to medical underwriting.

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

0 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_____

D Employee Only D Employee & Spouse D Employee & Child(ren) D Family

0 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 *mmlddlyyyy*	Relation to you	Check if Disabled	Medical	Dental	Vision
			OM OF	/ /	OSpouse OChild	O	O	O	O
			OM OF	/ /	OSpouse OChild	O	O	O	O
			OM OF	/ /	OSpouse OChild	O	O	O	O

			OM OF	/ /	OSpouse OChild	0	0	0	0
			OM OF	/ /	OSpouse OChild	0	0	0	0
			OM OF	/ /	OSpo use OChild	0	0	0	0
			OM OF	/ /	OSpouse OChild	0	0	0	0
			OM OF	/ /	OSpouse OChild	0	0	0	0
			OM OF	/ /	OSpouse OChild	0	0	0	0
			OM OF	/ /	OSpouse OChild	0	0	0	0
			OM OF	/ /	OSpouse OChild	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 requir4d 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 scan and email your completed form to HR@avemaria.edu