University of New England 2014 Benefits Enrollment/Change Form
Note: This form must be received by the HR Office within 30 days after the event.

(Payroll Use Only)
Benefit Eff. Date:_____
Input Elections:_____

UNE Faculty, Staff, Retiree, or COBRA Beneficiary information

Name: _____
(Last, First, Middle Initial)

Address: _____

_____

_____

Date of Birth: _____ **PRN:**_____

Daytime Phone: _____ **Date of Hire:**_____

Date of Event:_____

Position Status: **(18 Pay) Full-Time** ___ **(18 Pay) Half-Time** ___

Payroll Cycle: ___ **Salaried** ___**Hourly**
Benefit deductions based on: 9 months of pay

Type of Event

___ New Enrollment
___ Add a dependent (dependent = spouse or child)*
___ Cancel coverage
___ Drop a dependent (dependent = spouse or child) *
___ Change name, address, or Primary Care Physician
___ Change Supp. Life or STD volume
___ Open Enrollment

Reason:

___ New hire or newly eligible employee
___ Marriage
___ Birth/adoption/legal guardianship
___ Divorce
___ Death of dependent (dependent = spouse or child)
___ Dependent newly eligible for own employer's plan
___ Dependent's employer's open enrollment
___ Other (explain) _____

** Notice of COBRA Qualifying Event form is required.*

PRE-TAX DEDUCTIONS

Check the appropriate boxes to indicate your 2014 Medical and Dental elections.

Medical/Rx:	Individual	Single Parent	Two Adults	Family	Waive Coverage
CIGNA Basic					
CIGNA Enhanced					
CIGNA Plus					

Dental:	Individual	Single Parent	Two Adults	Family	Waive Coverage
Delta Dental Basic					
Delta Dental Enhanced					

Full-Time Waived Coverage Income: $50.00 [ ]
*Signature required on reverse page to Waive Medical Coverage

Do you have other Medical coverage? ___Yes ____No
If "Yes", effective date _____
Do you have other Rx coverage? ___Yes ____No
If "Yes", effective date _____

Other Group Coverage: (Coordination of Benefits)
Will you, your spouse, or any dependent be covered under any other group dental plan while this policy is in effect? ____Yes ____No
Will this dental coverage replace another Northeast Delta Dental Plan?
___Yes ___No

Per Pay Period:

Medical **A.** _____

Dental **B.** _____

Supplemental Life Insurance:
(a health statement may be required)

___ **1 x Salary**
___ **2 x Salary**
___ **3 x Salary**
___ **4 x Salary**
___ **Waive Coverage**

Coverage Amount _____/1000* rate/2= _____

C. _____

Reimbursement Accounts:

Medical Care: $_____ (Annual Amount) If electing, the minimum contribution is $250 and the maximum is $2,500. Enter $0 if waiving election. **D.** _____

Dependent Care: $_____ (Annual Amount) If electing, the minimum contribution is $250 and the maximum is $5,000. Enter $0 if waiving election. **E.** _____

POST-TAX DEDUCTIONS

Long Term Disability: (For Full-Time Status Only; the LTD income (see item L) covers the deduction cost.)

Per Pay Premium: Annual Salary/1800 * .27=
Maximum Premium: **$21.00** **F.** _____

Short Term Disability: **Age as of 1/1/2014:** _____

___ Elect STD Coverage $_____
___ Waive STD Coverage

If electing STD, enter the weekly benefit amount you wish to purchase ($50 increments up to a maximum of $750 or 70% of earnings) **G.** _____

Weekly Benefit Election/10*_____ (increment rate)/2= _____

Basic Life and AD&D Insurance: (For Full-Time Status Only)
Basic coverage equivalent to 1x your annual salary paid by UNE **H.** **No Cost**

Per Pay Period:

TOTAL DEDUCTIONS (Items A thru G)

TOTAL DEDUCTIONS **I.** _____

EMPLOYER PROVIDED INCOME CREDITS

EMPLOYER INCOME CREDITS (For Full Time Status Only)

Life Insurance Income Credits ($1.25) **J.** <_____>

Waived Medical Coverage Income Credit ($50.00) (if elected on Page 1) **K.** <_____>

Long Term Disability Income Credit (see item E) **L.** <_____>

TOTAL INCOME CREDITS **M.** <_____>

NET DEDUCTIONS OR INCOME CREDITS (Item I minus M)

NET DEDUCTIONS OR <CASH PAYMENT/INCOME CREDIT> **N.** _____

INSURANCE ELIGIBILITY DETAIL

Complete the following section for yourself and your dependents. For every person listed, indicate whether you are **A**-Adding, **D**-Deleting, or **C**-Changing coverage in each benefit column.

Name (Last, First, Middle Initial)	Social Security #	DOB	Relationship Code	Gender M / F	Medical	Dental

SL *=Self,* ***SP*** *= Spouse,* ***DP*** *=Domestic Partner,* ***D*** *=Daughter,* ***S*** *=Son,* ***SD*** *=Step Daughter,* ***SS*** *=Step Son*

LIFE INSURANCE BENEFICIARY DESIGNATION

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages the total must equal 100%.

Name: (Last, First, Middle Initial)	Social Security:	Date of Birth	Relationship	P or C	Benefit %

P=Primary Beneficiary, **C**=Contingent Beneficiary

Certification and Signature:
I have read the plan description and have chosen the benefits indicated, and agree to pay the asscociated per pay period salary deduction. I understand that these elections will remain in effect from year to year unless changed, except that flexible spending needs to be re-elected annually. I understand that If I do not return an election form during subsequent re-enrollment periods, any elections I have made with respect to health, dental , life insurance and short term disability coverage and beneficiaries will remain the same and the new per pay period cost will be adjusted. I understand that eligibility for UNE's benefit plans are subject to the specific plan documents and UNE's policies.

_____ _____
Signature of Faculty, Staff, Retiree, or COBRA Beneficiary **Date**

Waive Medical Coverage:
I wish to waive medical coverage. I certify that I have other medical insurance available to me through my spouse/partner/other (specify).
I understand that this election will remain in effect from year to year unless changed.

Name of Policy Holder:_____ Name of Employer:_____ Group Number:_____