

**University of New England 2015 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)      Date of Birth: \_\_\_\_\_      PRN: \_\_\_\_\_

Address: \_\_\_\_\_      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

<p><b>Type of Event</b></p> <p><input type="checkbox"/> New Enrollment</p> <p><input type="checkbox"/> Add a dependent (dependent = spouse or child)*</p> <p><input type="checkbox"/> Cancel coverage</p> <p><input type="checkbox"/> Drop a dependent (dependent = spouse or child) *</p> <p><input type="checkbox"/> Change name, address, or Primary Care Physician</p> <p><input type="checkbox"/> Change Supp. Life or STD volume</p> <p><input type="checkbox"/> Open Enrollment</p>	<p><b>Reason:</b></p> <p><input type="checkbox"/> New hire or newly eligible employee</p> <p><input type="checkbox"/> Marriage</p> <p><input type="checkbox"/> Birth/adoption/legal guardianship</p> <p><input type="checkbox"/> Divorce</p> <p><input type="checkbox"/> Death of dependent (dependent = spouse or child)</p> <p><input type="checkbox"/> Dependent newly eligible for own employer's plan</p> <p><input type="checkbox"/> Dependent's employer's open enrollment</p> <p><input type="checkbox"/> Other (explain) _____</p>
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\* Notice of COBRA Qualifying Event form is required.

**PRE-TAX DEDUCTIONS**

Check the appropriate boxes to indicate your 2015 Medical and Dental elections.

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

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      Coverage Amount \_\_\_\_\_/1000\* rate/2= \_\_\_\_\_  
 \_\_\_ 2 x Salary  
 \_\_\_ 3 x Salary      C.  
 \_\_\_ 4 x Salary  
 \_\_\_ Waive Coverage

**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 1/1/2015: \_\_\_\_\_**

\_\_\_ Elect 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.

\_\_\_ Waive STD Coverage

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.



**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	Ben

**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 associated 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

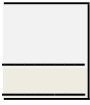
Date

**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: \_\_\_\_\_





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Daily	Waive Coverage

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**No Cost**

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Per Pay Period:

\_\_\_\_\_

< \_\_\_\_\_ >

< \_\_\_\_\_ >

< \_\_\_\_\_ >

< \_\_\_\_\_ >

\_\_\_\_\_

Benefit %


\_\_\_\_\_

