Employee ID_____
(Required)

2017 Benefits Program Enrollment Form for New Hires and Newly Benefit Eligible Employees

Please Print - Please Complete ALL Applicable Sections

Employee Information

Name (Last, First, Initial) *Please Print*: _____

Address: _____

_____

Gender (M/F): _____ **Date of Birth (MM/DD/YYYY):** _____ **Phone Number:** _____

E-mail Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

➢ **Date of Hire/Change to Eligible Status (MM/DD/YYY):_____**

University Health Care Plans

Please Select a Plan or Select to Waive	*Please Select Your Dependent Coverage Level*
☐ YO**UR** HSA-Eligible Plan ☐ YO**UR** PPO Plan ☐ Waive Medical Coverage	☐ Employee Only Coverage ☐ Employee and Spouse/Domestic Partner Coverage ☐ Employee and Child(ren) Coverage ☐ Family Coverage
Please Select a Third-Party Administrator (TPA) ☐ Aetna ☐ Excellus	

University Dental Assistance Plans*

Please Select a Plan or Select to Waive	*Please Select Your Dependent Coverage Level**
☐ Traditional Dental Plan ☐ Medallion Dental Plan ☐ Waive Dental Coverage	☐ Employee Only Coverage ☐ Family Coverage ***(Employee only coverage is considered single. Employee plus one or more dependents is considered family.)***
**Excellus is the Third-Party Administrator (TPA) for the Dental Assistance Plans*	

If you have any questions, please contact the University of Rochester Benefits Office at (585) 275-8382 or (585) 275-2084

Please return completed forms to: Benefits Office, 44 Celebration Dr., Suite 2300, P.O. Box 270453, Rochester, NY 14627; Fax: 585-273-1054 or Email: benefitoffice@hr.Rochester.edu

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Dependent Information

Spouse's Information	**Name (Last, First)** ____________________________________	**Gender (M/F)**	**Social Security Number*** (Required field for all dependents*)	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**	**Should be enrolled in Dental (Y/N)**
***Domestic Partner's Information**	**Name (Last, First)** ____________________________________	**Gender (M/F)**	**Social Security Number*** (Required field for all dependents*)	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**	**Should be enrolled in Dental (Y/N)**

If an employee adds a Domestic Partner, they will need to submit the <u>Certification of Domestic Partner Status form</u> and <u>Domestic Partner Tax Affidavit</u> on the Benefits website if applicable

Family Member's Information	**Name (Last, First)** ____________________________________ __ Child to age 26 __ DP's Child __ Handicapped**	**Gender (M/F)**	**Social Security Number*** (Required field for all dependents*)	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**	**Should be enrolled in Dental (Y/N)**
Family Member's Information	**Name (Last, First)** ____________________________________ __ Child to age 26 __ DP's Child __ Handicapped**	**Gender (M/F)**	**Social Security Number*** (Required field for all dependents*)	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**	**Should be enrolled in Dental (Y/N)**
Family Member's Information	**Name (Last, First)** ____________________________________ __ Child to age 26 __ DP's Child __ Handicapped**	**Gender (M/F)**	**Social Security Number*** (Required field for all dependents*)	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**	**Should be enrolled in Dental (Y/N)**

***** A <u>Handicapped Dependent form</u> is REQUIRED for these eligible dependents. Forms are available online at www.rochester.edu/benefits and at the Benefits Office. Please return completed forms to the address listed on the form.***

*<u>**Beginning with the 2015 Plan Year, the Affordable Care Act Regulations requires all insures and self-insured employer groups (UR) to report to the IRS the social security numbers (SSN) for each individual (employees and dependents) to whom the group provides minimum essential health care coverage (MEC) intended primarily to support the IRS' enforcement of the individual mandate.**</u> In addition to your own, please provide the SSN for each dependent to be enrolled under your University Health Care Plan. Under Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), third-party administrators of self-funded plans like the University of Rochester's Health Care Plans are required to meet new reporting requirements. Reportable information includes <u>Social Security Numbers of individuals whose health care plan coverage begins on or after 1/01/09, who are 45 or older, are covered by Medicare, or have end-stage renal disease.</u>

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Long-Term Disability (LTD)

Note: To add/increase LTD coverage after this initial enrollment eligibility period you would have to complete and submit a statement of health for approval by the insurance company. When applicable, forms can be obtained from Leave Administration.

Please Choose a Coverage Level

☐ I wish to apply for FULL coverage to which I am now entitles or may become entitles to in the future under the UR Long-Term Disability (LTD) Plan.

☐ I wish to LIMIT my coverage under the Long-Term Disability (LTD) Plan. I understand that the coverage to which I am now entitled or may become entitles will apply to my base salary up to $36,000, but will not protect any part of my present or future salary which is above $36,000 per year.

☐ FOR PART-TIME FACULTY AND STAFF ONLY: I wish to WAIVE my coverage under the UR Long-Term Disability (LTD) Plan. I understand that I will have no insurance coverage under the LTD Plan if I am totally disabled longer than six months.

NOTE: To apply for a waiver of the one year service requirement for LTD coverage because you have Long-Term Disability Insurance through a previous employer-sponsored group plan, please complete the section below.

I hereby certify that I was previously employer by _____ (previous employer) and was covered there under a group long-term disability plan providing income benefits for a minimum of 5 years for disability due to sickness. Date my coverage ended _____ (not more than 3 months prior to my UR appointment). The plan was insured by _____ (name of insurance company).

Flexible Spending Accounts (FSA)

If you wish to contribute to a Flexible Spending Account in 2016, please complete this section. 2015 contribution elections will not automatically rollover. **Please be sure to read the FSA Election of Reimbursement & Compensation Reduction Agreement prior to electing an FSA which can be found on the Benefits website under Flexible Spending Accounts.**

☐ Health Care FSA (Min $100, Max $2,550 annually)
Annual Healthcare FSA contribution of $_____

☐ Dependent Care FSA* (for Child/Daycare Services for dependent children up to age 13 or a qualified handicapped spouse or dependent child/tax dependent) (Min $100, Max $5,000 or $2,500 if married and filing separate tax returns)
Annual Dependent Care FSA contribution of $_____

***Please Note:** Federal non-discrimination guidelines require the University of Rochester to test Dependent Care FSA annually to ensure highly compensated employees, as defined under IRS guidelines, do not disproportionally contribute to the Dependent Care FSA. Highly compensated employees, who earned over 115,400 in the 2015 Plan Year, may have their FSA maximum contribution amount reduced if the test results do not meet federal guidelines.

Please return completed forms to: Benefits Office, 44 Celebration Dr., Suite 2300, P.O. Box 270453, Rochester, NY 14627; Fax: 585-273-1054 or Email: benefitoffice@hr.Rochester.edu

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Health Savings Account (HSA)

(This option requires enrollment in the University's YOUR HSA-Eligible Plan)

If Aetna is your Third-Party Administrator (TPA), your HSA will be through PayFlex. If Excellus is your TPA, your HSA will be through HSA Bank.

☐ Health Savings Account (Min $100, Max $3,400 with single University's YO**UR** HSA-Eligible Plan coverage, Max $6,750 with family University's YO**UR** HSA-Eligible Plan coverage. If you are age 55 or older you may contribute an additional $1,000) Annual* Health Savings Account contribution of $_____

Limited Purpose Flexible Spending Account (available only if you are contributing to a HSA)

☐ Limited Purpose FSA (Min $100 and Max $2,550 annually)
Annual* Limited Purpose FSA contribution of $_____

***The annual amount will be pro-rated for a deduction each pay period based on the number of pay periods remaining to be paid in the calendar year.**

Please note: Annual maximum contributions are pro-rated if enrollment in the University YOUR HSA-Eligible Plan occurs after January 1 of the calendar year.

Please note: A plan that covers an employee and one or more dependents is considering family coverage for HSA contribution limits.

Health Savings Account (HSA) Eligibility Criteria

To determine your ability to enroll in a Health Savings Account per the IRS Guidelines you will need to meet ALL the requirements below.

- ✓ You must elect coverage under the University's YO**UR** HSA-Eligible Plan for 2017.
- ✓ You cannot be covered by any other health plan (including spousal health insurance), except what the IRS permits.
- ✓ You cannot elect nor be covered by another person's Health Care Flexible Spending Account or Health Reimbursement Arrangement for 2017.
- ✓ You cannot be enrolled in any part of Medicare, Tricare, Medicaid or state health care programs.
- ✓ You cannot or will not be claimed as a dependent on another person's tax return for 2017.
- ✓ You cannot have received Veteran's Administration health benefits in the past 90 days (preventive, dental and vision is permitted).

☐ I declare that I **do not** meet all the requirements above to the best of my knowledge

☐ I declare that I **do** meet all the requirements above to the best of my knowledge

Signature: _____

If you do not meet the requirements to enroll in a Health Savings Account you may choose to enroll in a Flexible Spending Account

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Please review this form for completion and sign and date below.
Incomplete and/or unsigned forms will not be processed.

Authorize Elections and Certify Dependent Eligibility

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and each of my family members who are covered under the Plans are bound by the terms and conditions of the plan documents and associated administrative documents as from time to time are in effect and that these documents have been available (and will continue to be available) to me online at www.rochester.edu/benefits or in hard copy at the University of Rochester Benefits Office. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information to the Plan's Third-Party Administrators and insurance carriers. I make this acknowledgement and agreement on behalf of myself and each person who now or in the future accepts coverage under the terms of the Plan applicable to my coverage (who may include, for example, my spouse, and my eligible family dependents).

I authorize the University to deduct from my wages or salary the amount(s) indicated on the University of Rochester 2017 Health Care and Dental Plans Premium Rate Sheet to pay my share of the cost of being covered by University benefit plans I have elected. I understand that such pay deductions will generally be taken on an after-tax basis, with the exception of premium contributions toward the cost of Health Care Plan coverage for tax-qualified dependents, flexible spending accounts (FSA) contributions, or Health Savings Account (HSA) contributions, which will be taken on a before-tax basis. I understand that if I am enrolled in coverage through the University and not receiving paychecks from the University, I must continue to pay my share of the premium for the Health Care and Dental Plan coverage to continue coverage through the University. If the University does not receive payment for the coverage, the coverage will be terminated on the last day of the month in which the premium has been paid in full and notification of the coverage cancellation will be sent to the home address from the University. Employees whose coverage has been canceled due to non-payment will not be eligible to re-enroll in Health Care or Dental Plan coverage until the next Open Enrollment period and until the premiums past due are paid to the University. Employees returning to work with an outstanding balance will be subject to arrears billing.

By electing an FSA or HSA, I and the University of Rochester, hereby agree that my cash compensation will be reduced by the annual amount set forth in the FSA or HSA section of this form, pro-rated by the number of pay periods in 2017 (or by the number of pay periods remaining after the date of this agreement) and deducted from my pay in equal installments. I have read and understand the information contained in the Flexible Spending Account Election of Reimbursement & Compensation Reduction Agreement.

I understand that if I have knowingly included any false information or enrolled ineligible dependents, that coverage may be cancelled, upon one month's written notice and any benefit claims may be denied, and that I may be subject to disciplinary action including termination of employment to the extent permitted by law. I have read and understand the information defining dependent eligibility under the University of Rochester Health and Dental Plans. I certified that each of my dependents covered under my health care and/or dental plan(s) meet the University's current dependent eligibility requirements, and that I agree to notify the Benefits Office if their status changes during the plan year.

Signature: _____ Date: _____

If you have any questions, please contact the University of Rochester's Benefits Office at (585) 275-8382 or (585) 275-2084

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