UNIVERSITY OF ROCHESTER

2024 Benefits Program Qualifying Event Change Form

(Retiree) Please Print– Please Complete ALL Applicable Sections

Retiree Information

Name (Last, First, Initial):____

Address:____

____

Gender (M/F):__________ Date of Birth (MM/DD/YYYY):______________________

Retiree/Employee ID#:______________ Phone Number:______________________

E-mail Address:____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Retirement Date (Last Working Date): ________________________________

Please Check Desired Action

Please complete with date of qualifying event

❑ I am requesting a change to my Health and/or Dental Plan elections due to a Qualifying Event*
Date of Qualifying Event:__________________________________

❑ I am requesting a change to my spouse/domestic partner's Health Plan elections due to gaining/losing eligibility for Medicare/Medicaid.*
Date of Qualifying Event:__________________________________

❑ I would like to ADD a dependent(s) to my Health and/or Dental Plan due to a Qualifying Event*
Date of Qualifying Event:__________________________________

❑ I would like to REMOVE a dependent(s) from my Health and/or Dental Plan due to a Qualifying Event*
Date of Qualifying Event:__________________________________

***NOTE: Completed forms must be received by the Office of Total Rewards within 30 days of a qualifying event. For Medicare Advantage Plan changes, forms must be completed prior to the effective date of coverage.**

Please Return Forms

The Office of Total Rewards kindly requests that you email completed forms to **retireebenefits@ur.rochester.edu** OR through the mail at 60 Corporate Woods, Suite 310, P.O. Box 270453, Rochester, NY 14627

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Please Print– Please Complete ALL Applicable Sections

Qualifying Events

NOTE: **This section must be completed for any request to change University Health or Dental Account elections outside of the annual open enrollment period due to a qualifying event. Requests must be received within 30 days of the qualifying event to be approved.** Changes due to retirement will be effective the 1st of the month following the retirement date. All other qualifying event changes will be effective the date of the qualifying event or the date the form is completed, whichever is later.

Please Select the Qualifying Event

- ❑ Retirement
- ❑ Legal Marriage/Domestic Partnership*
- ❑ Legal Separation or Divorce
- ❑ Termination of Domestic Partnership
- ❑ Birth of a Child/Adoption of a Child
- ❑ Dependent Gains Eligibility Through Their Own Employer or Parent's Coverage
- ❑ Loss of Coverage
- ❑ Gain Eligibility for Medicare/Medicaid
- ❑ Lose Eligibility for Medicare/Medicaid
- ❑ Retiree/Dependent Open Enrollment
- ❑ Dependent Passes Away
- ❑ Lose Eligibility for Medicare Advantage Plan Due to Change in Permanent Residence
- ❑ Retiree/Dependent Enrolls in Coverage Through Public Health Insurance Exchange/ Marketplace
- ❑ Retiree/Dependent Loses Coverage Through Public Health Insurance Exchange/Marketplace

* A **Certification of Domestic Partners Status Form** is REQUIRED for eligible domestic partners. Also, if your domestic partner and/or his/her dependent children qualify as your tax dependent under Federal law, an **Affidavit of Domestic Partner's (Opposite-Sex and Same -Sex) Federal Tax Dependent Status for University Health Benefit Plans Form** is required. Forms are available online at www.rochester.edu/totalrewards and at the Office of Total Rewards. Please return completed forms to 60 Corporate Woods, Suite 310, PO Box 270453, Rochester, NY 14627.

If you or any of your dependents are currently covered under another University Heath or Dental Plan through a relative employed by the University, please provide the name of the relative below:

Name: ____

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Retiree/Employee ID _______________ 1/2024

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Spouse's Information Name:_______________	Social Security # (Required field for certain dependents *) SS#__________	Gender M/F ❑ M ❑ F	Date of Birth (MM/DD/YY) __________	Would you like to cover on your **University Health Care Plan** ❑ YES ❑ NO	Would you like to cover on your **University Dental Plan** ❑ YES ❑ NO
Domestic Partner (DP) Information Name:_______________	Social Security # (Required field for certain dependents *) SS#__________	Gender M/F ❑ M ❑ F	Date of Birth (MM/DD/YY) __________	Would you like to cover on your **University Health Care Plan** ❑ YES ❑ NO	Would you like to cover on your **University Dental Plan** ❑ YES ❑ NO
Dependent Children's Information (If your dependent child is Handicapped please check the appropriate box in addition)	Social Security # (Required field for certain dependents *)	Gender M/F	Date of Birth (MM/DD/YY)	Would you like to cover on your **University Health Care Plan**	Would you like to cover on your **University Dental Plan**
Name:_______________ ☐ Employee's Child ☐ DP's Child ☐ Handicapped Child**	SS#__________	❑ M ❑ F	__________	❑ YES ❑ NO	❑ YES ❑ NO
Name:_______________ ☐ Employee's Child ☐ DP's Child ☐ Handicapped Child**	SS#__________	❑ M ❑ F	__________	❑ YES ❑ NO	❑ YES ❑ NO
Name:_______________ ☐ Employee's Child ☐ DP's Child ☐ Handicapped Child**	SS#__________	❑ M ❑ F	__________	❑ YES ❑ NO	❑ YES ❑ NO
Name:_______________ ☐ Employee's Child ☐ DP's Child ☐ Handicapped Child**	SS#__________	❑ M ❑ F	__________	❑ YES ❑ NO	❑ YES ❑ NO

* The Affordable Care Act Regulations requires all insurers and self-insured employer groups (UR) to report to the IRS the social security numbers (SSN) for each individual (retirees and dependents) to whom the group provides minimum essential health care coverage (MEC) intended primarily to support the IRS' enforcement of the individual mandate. In addition to your own, please provide the SSN for each dependent to be enrolled in your University Health Care Plan.

** A Handicapped Dependent Form is REQUIRED for these eligible dependents. Forms are available online at www.rochester.edu/totalrewards and at the Office of Total Rewards. Please return completed forms to 60 Corporate Woods, Suite 310, PO Box 270453, Rochester, NY 14627.

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University Dental Plans

Coverage level is determined by dependent elections on Page 3 of this form. Retiree only coverage is considered single, Retiree plus one or more dependents is considered family.

- ☐ I choose to Elect coverage under the University Traditional Dental Assistance Plan
- ☐ I choose to Elect coverage under the University Medallion Dental Plan
- ☐ I choose to Waive University Dental Plan Coverage

University Non-Medicare-Eligible Retiree Health Care Plans

Please Select a Plan or Select to Waive

Excellus will be the third party administrator

- ☐ YO**UR** PPO Plan
- ☐ YO**UR** HSA-Eligible Plan
- ☐ Waive University Health Care Plan Coverage

University Medicare-Eligible Retirees

Please Select Your Plan of Enrollment

For enrollment in Medicare eligible plans, please contact Via Benefits at 1-833-945-1110 or utilize the robust decision-support tools available online at my.viabenefits.com/UniversityofRochester.

- ☐ I will be enrolling in a plan through Via Benefits.
- ☐ I will be enrolling in a plan elsewhere.

 Please Continue to Page 5

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

Authorize Elections and Certify Dependent Eligibility

I acknowledge and agree that by signing this qualifying event change form and subsequently accepting services, I and each of my family members who is 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/totalrewards or in hard copy at the University of Rochester Office of Total Rewards. 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 other 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 understand that as a Retiree I am responsible to pay my share of the Health and Dental premiums to continue coverage through the University. If the University does not receive payment for my coverage, I understand the coverage will be terminated on the last day of the month for which the premium has been paid in full and notification of the coverage cancellation will be sent to the home address from the University. I understand if my coverage has been cancelled due to non-payment, I will not be eligible to re-enroll in a Health Care plan or Dental plan until the next Open Enrollment period and until premiums past due are paid to the University.

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. 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 to be 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 Office of Total Rewards if their status changes during the plan year.

Signature

I acknowledge that providing my electronic approval is equivalent to signing the document and I understand that my electronic signature is binding. I understand that it may take up to one full pay period to process this change.

______________________________ ______________________

Signature **Date**