TOTAL REWARDS
HUMAN RESOURCES
UNIVERSITY OF ROCHESTER

Employee ID__________
(Required)

2019 Benefits Program Qualifying Event Change Form

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

Please Check Desired Action - *Please complete with date of qualifying event*

☐ I am requesting a change to my Health Care Plan and/or Dental Plan elections due to a Qualifying Event*

Date of Qualifying Event: ___________ (complete entire form)

☐ I am requesting a change to my Flexible Spending Account (FSA) elections due to a Qualifying Event*

Date of Qualifying Event: ___________ (complete pages 1, 2, 4 and 6)

☐ I am requesting a change to my annual Health Savings Account election (University HSA-Eligible Plan Participants only) **(complete pages 1, 5 and 6)**

☐ I would like to ADD a dependent(s) to my Health Care Plan and/or Dental Plan elections due to a Qualifying Event*

Date of Qualifying Event: ___________ (complete pages 1, 2, 3, and 6)

☐ I am requesting to REMOVE a dependent from my Health Care Plan and/or Dental Plan elections due to a Qualifying Event*

Date of Qualifying Event: ___________ (complete pages 1, 2, 3 and 6)

***NOTE: Completed forms must be received by the Benefits Office within 30 days of hire/eligibility/qualifying event.**

Incomplete forms cannot be processed.

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

Please return completed forms to: Office of Total Rewards, 60 Corporate Woods, Suite 310, P.O. Box 270453, Rochester, NY 14627 or Email: TotalRewards@Rochester.edu

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Qualifying Events

NOTE: **This section must be completed for any request to change University Health, Dental, or Flexible Spending Account elections outside of the annual open enrollment period due to a qualifying event. Changes due to a qualifying event must be received within 30 days (within 60 days for loss of Medicaid or CHIP coverage or eligibility for a state's premium assistance program) of the qualifying event**. **Coverage changes will generally be effective on the date of the qualifying event or the date the completed form is received, whichever is later. Where a coverage change is effective mid-way through a payroll period, your employee contribution for that payroll period will be determined based on your coverage election in effect as of the last day of the payroll period.** Changes for newly born and newly adopted children will be effective the date of birth or placement for adoption. Please refer to the Appendix A in the Health Program Guide for a list of benefit changes allowed outside of Open Enrollment

Please Select the Appropriate Qualifying Event

- ☐ Legal Marriage/Domestic Partnership*
- ☐ Legal Separation or Divorce
- ☐ Termination of Domestic Partnership
- ☐ Birth of a Child/Adoption of a Child
- ☐ Gain Eligibility of Medicaid/Medicare
- ☐ Loss Eligibility of Medicaid/Medicare
- ☐ Approved Leave (i.e. FMLA, Military Leave, Layoff)
- ☐ Return from Leave (i.e. FMLA, Military Leave, Layoff)
- ☐ Retirement
- ☐ Other: ____
- ☐ Loss of Coverage
- ☐ Spouse/Domestic Partner Open Enrollment Parent/Dependent Child
- ☐ Spouse/Dependent Passes Away
- ☐ Dependent Gains Eligibility Through Their Own Employer or Parent's Coverage
- ☐ Change in Cost of Care for Dependent Care FSA
- ☐ Significant increase in the employee's share of health care premiums
- ☐ Significant decrease in the employee's share of health care premiums

*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/benefits and at the Office of Total Rewards. Please return completed forms to the Office of Total Rewards, 60 Corporate Woods, Suite 310 or P.O. Box 270453 via intramural

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

Name: ____

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Dependent Information (Please print)

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/totalrewards and at the Total Rewards 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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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 *****Excellus is the Third-Party Administrator (TPA) for the Dental Assistance Plans*	☐ Employee Only Coverage ☐ Family Coverage ***(Employee only coverage is considered single. Employee plus one or more dependents is considered family.)***

Flexible Spending Accounts (FSA)

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 $2,650 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 120,000 in the 2018 Plan Year, may have their FSA maximum contribution amount reduced if the test results do not meet federal guidelines.

If applicable: You might consider dividing your desired annual maximum contribution between you and your spouse/partner.

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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 (Max $3,500 with single University's YO**UR** HSA-Eligible Plan coverage, Max $7,000 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 $2,650 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 2019.
- ✓ 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 2019.
- ✓ 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 2019.
- ✓ 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

Employee ID__________
(Required)

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/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 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 2019 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 2019 (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 Office of Total Rewards if their status changes during the plan year.

Signature: ____ **Date:** ___________

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

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