Northeastern University

Benefits Enrollment Form

Human Resources Management
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CHECK REASON THAT YOU ARE COMPLETING THIS ENROLLMENT FORM*

❑ New hire ❑ Qualifying event or family status change

* *New hires should complete this entire form. If you are completing this form because of a qualifying event, you need only enter new or changed information.*

Qualifying events are defined in the Benefits and Services Summary. Changes must be submitted within 30 days of the qualifying event and documentation is required.

_____/_____/_____
Effective date (mm/dd/yyyy)

EMPLOYEE INFORMATION

Name (Last, First, Middle initial) _____ Social Security number _____

Date of birth _____ Date of hire _____ Marital status _____

HEALTH INSURANCE

Medical

❑ Individual
❑ Family
❑ Terminate
❑ Waive participation

I select the following plan *(choose one)*:

❑ Blue Cross Blue Shield POS
❑ Blue Cross Blue Shield HMO
❑ Blue Cross Blue Shield PPO

Dental *(Dental coverage provided by Delta Dental of Massachusetts)*

❑ Individual
❑ Family
❑ Terminate
❑ Waive participation

HEALTH INSURANCE DEPENDENT AND PRIMARY CARE PHYSICIAN INFORMATION

List those dependents (spouse, same-sex spousal equivalent, or dependent child) for whom you are selecting medical and dental coverage and their primary care physician (PCP) information. Please attach required documentation for dependents as follows: spouse – marriage certificate, same-sex spousal equivalent – certification, dependent child – birth certificate or your most recent 1040 Tax Return which lists your dependents.

Medical	Dental	Name (Last, First, MI)	Social Security #	D.O.B.	Gender	Student?	Relationship	PCP#
❑	❑			/ /	M F	–	self	
❑	❑			/ /	M F	❑		
❑	❑			/ /	M F	❑		
❑	❑			/ /	M F	❑		
❑	❑			/ /	M F	❑		

REIMBURSEMENT ACCOUNTS

Check the account(s) you wish to establish and indicate the calendar year election for each. Reimbursement accounts must be elected each calendar year during open enrollment.

Health Care Reimbursement Account ❑ Amount: $ _____ *($120 minimum and $2,500 maximum per calendar year)* ❑ Waive participation

Dependent Care Reimbursement Account ❑ Amount: $ _____ *($120 minimum and $5,000 maximum per calendar year)* ❑ Waive participation

LIFE INSURANCE

Basic Life Insurance

2x base salary paid by Northeastern University.

Benefits reduction begins at age 65.

Same-sex spousal certification is required.

Optional Life Insurance

Employee

❑ 1x base salary
❑ 2x base salary
❑ 3x base salary
❑ 4x base salary
❑ Waive participation

Spouse/Same-sex spousal equivalent

Date of Birth: _____/_____/_____

❑ $25,000
❑ $50,000
❑ $75,000
❑ $100,000
❑ Waive participation

Dependent Child(ren)

❑ $10,000
❑ $20,000
❑ Waive participation

BENEFICIARY INFORMATION

List the beneficiary or beneficiaries for your life insurance coverage. All benefits-eligible employees have basic life insurance provided by Northeastern University.

Name (Last, First, Middle initial)	Relationship	Primary/Contingent *(circle one)*	Benefit percent
		Primary Contingent	%
		Primary Contingent	%
		Primary Contingent	%
		Primary Contingent	%

I certify the above is true and correct. I acknowledge that I have been given the Northeastern Benefits and Services Summary and have been given the opportunity to enroll in the Northeastern Benefits Plans. By not enrolling in certain benefits at this time, I realize that I will be unable to enroll or make changes again until the next open enrollment unless I have a qualifying event (medical, dental, and reimbursement accounts) or a family status change (life insurance) as outlined in the Benefits and Services Summary. I hereby authorize Northeastern University to reduce my pay for the benefit plans I have selected above.

Employee signature _____ Date _____

Reviewed by _____ Entered _____