Northeastern University
Human Resources Management

2016 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 on HRM's website: northeastern.edu/hrm. 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	I select the following plan *(choose one)*:	**Dental**	I select the following plan *(choose one)*:	**Vision Plan**
❑ Individual	❑ HDHP W/HSA	❑ Individual	❑ Value	❑ Individual
❑ Family	❑ Core	❑ Family	❑ Value Plus	❑ Family
❑ Terminate	❑ Enhanced	❑ Terminate		❑ Terminate
❑ Waive participation	❑ PPO	❑ Waive participation		❑ Waive

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**	**Vision**	**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 amount for each. Reimbursement accounts must be elected each calendar year during open enrollment.

Health Care Reimbursement Account ❑ Amount: $ _____ *($120 minimum and $2,550 maximum per calendar year)* ❑ Waive participation

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

HEALTH SAVINGS ACCOUNT (HSA)

Select the amount you wish to contribute for the calendar year. The HSA may only be used if you have selected the High Deductible Health Plan offered by Northeastern.

Health Savings Account ❑ Amount: $ _____

By enrolling in the HSA and checking this box __, I certify that I meet the IRS eligibility requirements for the HSA. *$3,350 maximum for individual, $6,750 maximum for family; the maximum includes the combined ($500/individual, $1,000/family) employer and employee contribution. If you will be 55 or older during the calendar year, you are eligible for a $1,000 catch up.*

LIFE INSURANCE

Basic Life Insurance	2x base salary paid by Northeastern University.					
Supplemental Life Insurance	❑ 1x base salary	❑ 2x base salary	❑ 3x base salary	❑ 4x base salary	❑ Waive	
Spouse/Domestic Partner	**Date of Birth:** __/__/__	❑ $25,000	❑ $50,000	❑ $75,000	❑ $100,000	❑ Waive
Dependent Child(ren)	❑ $10,000	❑ $20,000	❑ Waive			

VOLUNTARY BENEFIT

Legal Plan ❑ Individual/family ❑ 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 reviewed the benefits outlined on northeastern.edu/hrm 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 as outlined on northeastern.edu/hrm. I hereby authorize Northeastern University to reduce my pay for the benefit plans I have selected above.

Employee signature _____ Date _____

Reviewed by _____ Entered _____