Campus Location	LTD Effective Date	NYS DBL Effective Date	Optional Life/AD&D Effective Date NY	Optional Life/	Basic Life/AD&D Effective Date		Vision Effective Date	Dental Effective Date	Health Effective Date
DATE		EE SIGNATURE	norization will EMPLOYE	indicated. This authax basis unless a w	d, if any, for the insurance eduction is paid on a pre-	the amount required dental insurance de edical insurance de	m my salary of a g. Medical and ok for pre-tax m	I hereby authorize deductions from my salary of the amount required, if any, for the insurance indicated. This authorization will be in effect until revoked in writing. Medical and dental insurance deduction is paid on a pre-tax basis unless a waiver form is submitted. (See Benefits Handbook for pre-tax medical insurance deduction information.)	PART I I hereby be in eff submitte
Dependent died     Divorce     Birth/Adoption	Newly eligible for coverage Child reached age limit No longer a student		Reason for change:  Marriage Spouse's coverage terminated Other, specify	Reason  Ma Spc Oth	Traditional PP0 Deductible PP0 HM0 Plan Decline Coverage Other	To:   Tradit	PPO PPO erage	From: Traditional PPO Deductible PPO HMO Plan Decline Coverage Other	☐ Moving out of area
The second secon	lange:	NGES Date of change:	DEPENDENT COVERAGE CHANGES	DEPEN		Date of change:		-	PART I MEDIC
	☐ I Decline Coverage	equired)	I Elect Coverage (Additional		erage	☐ I Decline Coverage	ired	I Elect Coverage (Additional form required)	
	ILITY INSURANCE	HORT-TERM DISABILITY INSURANCE	OPTIONAL SUPPLEMENTAL SI		SMEMBERMENT INSUI	AL DEATH AND DI	ND ACCIDENT	DEPENDENT OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	PART G DEPEN
			on the back of this form.	different beneficiaries	Life (Part E), unless you list	he same as for Basic	ficiaries will be to	List additional beneficiaries on back of this form. Beneficiaries will be the same as for Basic Life (Part E), unless you list different beneficiaries on the back of this form.	List additional beneficiarie
	6X	4X		gs	Multiple of earnings	atement required	or medical sta	Employee Paid – Submit within 60 days of hire or medical statement required	Employee Paid - Subm
		I Decline Coverage		☐ I Elect Coverage	ENT INSURANCE	ID DISMEMBERM	TAL DEATH AN	OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	PART - OPTION
contains more than one person, the benefit is apportioned equally unless specified otherwise.)	imary beneficiaries are dece	eneficiary ONLY if all pri	t is payable to contingent be	k of this form. Benefi	e.)	ss specified otherwis	ned equally unles	contains more than one person, the benefit is apportioned equally unless specified otherwise.)	contains more than one pe
Primary Contingent								booting to the same of	*IMPORTANT: Diagon list
				Commission of the commission o					
☐ Primary ☐ Contingent				And the second s					
Primary-Class 1 Contingent-Class 2	Prima			ADDRESS	DATE OF BIRTH ADD	ENT RELATIONSHIP	PERCENT		NAME
BENEFICIARY DESIGNATION			ř.*	MENT INSURANC	EATH AND DISMEMBE	ND ACCIDENTAL D	BASIC LIFE AL	BENEFICIARY DESIGNATION – BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE*	
□ Dental	□ M						The state of the s		
☐ Dental	□ M						The state of the s		
☐ Medical ☐ Dental ☐ Vision	□ M					Assumed the contract of the co			
☐ Medical ☐ Dental ☐ Vision	□ M				Manager of the second s				
TYPE OF COVERAGE	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER SOI	MI	NAME	FIRST NAME	ME	00
				OF THIS FORM	<b>EPENDENTS ON BACK</b>	NY ADDITIONAL D	FULL - LIST A.	DEPENDENTS - COMPLETE IN FULL - LIST ANY ADDITIONAL DEPENDENTS ON BACK OF THIS FORM	된
	☐ I Decline Coverage	☐ Family ☐ I	Employee Only	VISION COVERAGE	☐ I Decline Coverage	☐ Family ☐ I [	Employee Only	DENTAL COVERAGE   Emplo	PART C DENTA
		ntation and approval)	equires additional documer	lomestic Partner (R	☐ Employee & Spouse or Domestic Partner (Requires additional documen	Employee & Family		the following:  Employee & Child(ren)	☐ Employee Only ☐ Employee 8
☐ I Decline Coverage			onal form required):	HMO Name (Additional form required):	Deductible PPO	Traditional PPO		MEDICAL INSURANCE COVERAGE	CAME OF MEDIC
	E-MAIL ADDRESS	JNE	ZIP CODE TELEPHONE	STATE		YTI3		0. B0X	
ABER	SOCIAL SECURITY NUMBER	JANGED)	FORMER LAST NAME (IF CHANGED)	M		FIRST			Name:
	Employment Date:		Date of Birth:	Female	Sex:   Male	Not Married		Legal Marital Status:	PART A Legal N
Name (complete ratis A, I) Life Insurance Beneficiary (Complete Parts A, E, F, I) Optional Life Insurance (Complete Parts A, F, I)	<b>Optional Life Insurance</b> (Complete Parts A, F, J)		Tanaba Tanaban,		ú			<b>Enrollment Form</b>	Benefits Enr
ts A, B, C, D, F, G, H, I) arts A, B, D, H, I)	Coverage (Complete Parts A, B, C, D, F, G, H, I) Health Plan (Complete Parts A, B, D, H, I)	Change:	new circument (Waiting periods apply, Please refer to Benefits Handbook)  Late Enrollment (Please refer to Benefits Handbook) for rules on late enrollment.)  Open Enrollment (Waiting periods anniv Please refer to Reporter Handbook)	oply. Please refer to refits Handbook for	new circulment (Waiting periods apply, Please refer to Benefits Handbook)  Late Enrollment (Please refer to Benefits Handbook) for rules on late enrollmen  Open Enrollment (Waiting periods annly Please refer to Benefits Handbook)	Late Enrolli  Open Enrol		,	
		]	D - F - 11 - JL - 11	-i. Diaman safar to	mant Milatina nariade a				