☐ **New Enrollment** (Waiting periods apply. Please refer to *Benefits Handbook*.)
☐ **Late Enrollment** (Please refer to *Benefits Handbook* for rules on late enrollment.)
☐ **Open Enrollment** (Waiting periods apply. Please refer to *Benefits Handbook*.)

☐ **Change:** ☐ **Coverage** (Complete Parts A, B, C, D, F, G, H, I)
☐ **Health Plan** (Complete Parts A, B, D, H, I)
☐ **Name** (Complete Parts A, I)
☐ **Life Insurance Beneficiary** (Complete Parts A, E, F, I)
☐ **Optional Life Insurance** (Complete Parts A, F, I)

# Benefits Enrollment Form

**PART A** Legal Marital Status: ☐ Married ☐ Not Married | Sex: ☐ Male ☐ Female | Date of Birth: | Employment Date:

Name: (LAST / FIRST / MI) | FORMER LAST NAME (IF CHANGED) | SOCIAL SECURITY NUMBER

Address: (STREET OR P.O. BOX / CITY / STATE / ZIP CODE) | TELEPHONE ( ) | E-MAIL ADDRESS

**PART B** **MEDICAL INSURANCE COVERAGE** ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Name (Additional form required): ☐ I Decline Coverage

**Please choose one of the following:**
☐ **Employee Only** ☐ **Employee & Child(ren)** ☐ **Employee & Family** ☐ **Employee & Spouse or Domestic Partner** (Requires additional documentation and approval)

**PART C** **DENTAL COVERAGE** ☐ Employee Only ☐ Family ☐ I Decline Coverage | **VISION COVERAGE** ☐ Employee Only ☐ Family ☐ I Decline Coverage

**PART D** **DEPENDENTS – COMPLETE IN FULL – LIST ANY ADDITIONAL DEPENDENTS ON BACK OF THIS FORM**

| ADD | DELETE | LAST NAME | FIRST NAME | MI | GENDER | SOCIAL SECURITY NUMBER | DATE OF BIRTH | RELATIONSHIP | TYPE OF COVERAGE |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | | | | | | | | ☐ Medical ☐ Dental ☐ Vision |
| ☐ | ☐ | | | | | | | | ☐ Medical ☐ Dental ☐ Vision |
| ☐ | ☐ | | | | | | | | ☐ Medical ☐ Dental ☐ Vision |
| ☐ | ☐ | | | | | | | | ☐ Medical ☐ Dental ☐ Vision |
| ☐ | ☐ | | | | | | | | ☐ Medical ☐ Dental ☐ Vision |

**PART E** **BENEFICIARY DESIGNATION – BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE***

| NAME | PERCENT | RELATIONSHIP | DATE OF BIRTH | ADDRESS | BENEFICIARY DESIGNATION |
|---|---|---|---|---|---|
| | | | | | Primary–Class 1 Contingent–Class 2 |
| | | | | | ☐ Primary ☐ Contingent |
| | | | | | ☐ Primary ☐ Contingent |
| | | | | | ☐ Primary ☐ Contingent |

***IMPORTANT**: Please list your beneficiaries for your Basic Life and AD&D insurance. List additional beneficiaries on back of this form. Benefit is payable to contingent beneficiary ONLY if all primary beneficiaries are deceased. (If a class of beneficiaries contains more than one person, the benefit is apportioned equally unless specified otherwise.)

**PART F** **OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE** ☐ I Elect Coverage ☐ I Decline Coverage

**Employee Paid – Submit within 60 days of hire or medical statement required** | Multiple of earnings ☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X ☐ 6X ☐ 7X

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.

**PART G** **DEPENDENT OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**
☐ I Elect Coverage (Additional form required) ☐ I Decline Coverage

**OPTIONAL SUPPLEMENTAL SHORT-TERM DISABILITY INSURANCE**
☐ I Elect Coverage (Additional form required) ☐ I Decline Coverage

**PART H** **MEDICAL INSURANCE PLAN CHANGE** Date of change:

☐ Open Enrollment
☐ Moving out of area

From: ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Plan _____ ☐ Decline Coverage ☐ Other _____

To: ☐ Traditional PPO ☐ Deductible PPO ☐ HMO Plan _____ ☐ Decline Coverage ☐ Other _____

**DEPENDENT COVERAGE CHANGES** Date of change:

**Reason for change:**
☐ Marriage ☐ Spouse's coverage terminated ☐ Other, specify _____
☐ Newly eligible for coverage ☐ Child reached age limit ☐ No longer a student
☐ Dependent died ☐ Divorce ☐ Birth/Adoption

**PART I** 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.)

EMPLOYEE SIGNATURE | DATE

| **Health** Effective Date | **Dental** Effective Date | **Vision** Effective Date | **Basic Life/AD&D** Effective Date | **Optional Life/AD&D** Effective Date | **NYS DBL** Effective Date | **LTD** Effective Date | Campus Location |
|---|---|---|---|---|---|---|---|
| | | | | | | | |