	Campus Location	LTD Effective Date	NYS DBL Effective Page		Optional Life/AD&D Effective Date		Basic Life/AD&D Effective Date	Vision Effective Date	Dental Effective Date	Health Effective Date
	DATE	6	EMPLOYEE SIGNATURE		d. This authorization vunless a waiver form	he insurance indicate aid on a pre-tax basis rmation.)	required, if any, for the rance deduction is parance deduction information information information in the requirement of the re	y salary of the amount fedical and dental insu or pre-tax medical insu	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.)	be in effer submitted
		Child reached age limit Ne longer a student		Other, specify	Other, specify	(D)	Other Overage	ge	Decline Coverage Other	
	Dependent died	Newly eligible for coverage		ge:	Reason for change: Marriage		☐ Iraditional PPU☐ Deductible PPO☐ HMO Plan	0		☐ Moving out of area
		inge:	ES Date of	VERAGE CHAN	DEPENDENT COVERAGE CHANG		ge:	Date of c	From: Traditional PPO	<u>_</u> =
		Coverage	orm required)	age (Additional fo	☐ I Elect Coverage (Additional form required)		CX-Libecline Coverage	lired)	MEDICAL INSTRANCE BLAN CHANCE	PART H MEDICAL
		.ITY INSURANCE	OPTIONAL SUPPLEMENTAL SHORT-TERM DISABILITY INSURANCE	LEMENTAL SH	OPTIONAL SUPP	MENT INSURANCE	AND DISMEMBERN	ACCIDENTAL DEATH	FIRST COVERAGE (Additional Life and accidental death and dismemberment insurance	PARI G DEPEND
		6X	□ 5X	ck of this form.	eneficiaries on the bac	unless you list different t	for Basic Life (Part E), u	ries will be the same as	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 beneficiaries
			Coverage	□ I Decline	A1X 20	Multiple of earnings	quired Multip	medical statement re	Employee Paid – Submit within 60 days of hire or medical statement required	Employee Paid – Submit
	deceased. (If a class of beneficiaries	nary beneficiaries are	nericially ONE; it all pill	90		ANDE	OTHERWISE.)	DEATH AND DISME	OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INCIDENTAL	PART F OPTION
	contains more than one person, the henefit is apportioned compile		naficiany ONIIV if all a li	to continuent her	orm. Benefit is pavable	liciaries on back of this	e. List additional benef	Life and AD&D insurance	ur beneficiaries for your Basic	contains more than one per
	☐ Primary ☐ Contingent									***************************************
	☐ Primary ☐ Contingent									
	Primary-Class 1 Contingent-Class 2					BIRTH ADDRESS	KELATIONSHIP DATE OF BIRTH	renceN: KED		
	IARY DESIGNATI				NSURANCE*	DISMEMBERMENT	ENIAL DEATH AND	סוס בוו ב הואם אכיכום	BERGENT REACTOR IN A COLORNIA	
	□ Dental □			-			ENTAI DEATH AND	SIC HEF AND ACCID	JARY DESIGNATION - BA	PART E BENEFIC
	□ Dental									
	□ Dental		14.14							
	Medical Dental Vision						The same of the sa		The first property of the first party and the	
								Martin Commerce of		
	TYPE OF COVERAGE	RELATIONSHIP	DATE OF BIRTH	TY NUMBER	ER SOCIAL SECURITY NUMBER	MI GENDER		FIRST NAME		
		90				S ON BACK OF THIS	IONAL DEPENDENT	LL - LIST ANY ADDIT	LAST NAME	_
		☐ I Decline Coverage	☐ Family ☐ []	Employee Only	VISION COVERAGE En	erage VISION	☐ I Decline Coverage	ee Only	DENTAL COVERAGE TEMPLOYEE Only	PART D DEDENIA
			itation and approval)	ditional documen	: Partner (Requires ad	 Employee & Spouse or Domestic Partner (Requires additional documentation and approval) 		☐ Employee & Family	☐ Employee & Child(ren)	C Employee Only
,	☐ I Decline Coverage			required):	(Additional form required):				ne following:	Please choose one of the following:
	apez 15@amail"	E-MAIL ADDRESS	NE 563 4500	26 (315)	STATE ZIP CODE		Southfield Deductible PPO	AV P Traditional PPO	MEDICAL INSURANCE COVERAGE	PART B MEDICA
	5	SOCIAL SECURITY NUMBER	(ANGED)	FORMER LAST NAME (IF CHANGED)		7	A COUNTY	Lot	10x 2	Name: STREET OR P.C
)2 13 2009	Employment Date:	1998	Birth:		Male & Femal	Sex:	Not Married	Legal Marital Status: Married	LAS LAS
	Life Insurance Beneficiary (Complete Parts A, E, F, I) Optional Life Insurance (Complete Parts A, F, I)	Life Insurance Ben Optional Life Insur						,	ollment Form	CS.
	Health Plan (Complete Parts A, B, D, H, I) Name (Complete Parts A, I)	Health Plan (Complete Part Name (Complete Parts A. I)	-B	ate enrollment.) Handbook.)	ase refer to <i>Benefits</i>	Open Enrollment (Vaiting periods apply. Please refer to Benefits Handbook.)	en Enrollment (Wa	01		
	Coverage (Complete Parts A. B. C. D. E.G. H. III	Coverage (Complet	☐ Change: ☐	Handbook.)	ase refer to Benefits	New Enrollment (Waiting periods apply, Please refer to Benefits Handbook.) Late Enrollment (Please of the Books, 1997).	e Enrollment (Wai			