STETSON UNIVERSITY

Stetson University Benefits Enrollment/Change Form 800_____Eff. Date 1/1/2020

Personal Information

Employee Name (Last, First, MI)	Social Security #	Birth Date	Sex M ☐ F ☐

Employee Address	City	State	Zip	County

Date of Hire	Home Phone	Annual Salary	Occupation

Reason for Enrollment/Change:

☐ New Hire ☐ Open Enrollment ☐ Birth/Adoption ☐ Marriage/Domestic Partnership ☐ Divorce

☐ Legal Separation ☐ Qualifying Event ☐ Dependent Reached Maximum Age ☐ Eligible for Other Coverage

☐ Termination, Term Date_____ ☐ Other, Please Explain: _____

*Evidence of eligibility to make changes is required for any type except New Hire and Open Enrollment

Coverage Elections

Medical (Cigna Open Access Plan) Choose One

☐ Cigna OAP Performance (comparable to a HMO)

☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

☐ Cigna OAP Option (comparable to a PPO)

☐ Employee Only ☐ Employee+ Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

☐ I Decline Medical Coverage (if declining coverage, are you covered under another plan? ☐ Yes ☐ No

Insurance Carrier_____ Group Policy Number_____

On the day coverage begins, will you or any family members enrolling in this plan be covered by any other group/individual health insurance or Medicare/Medicaid? ☐ Yes ☐ No If yes:☐ Group Coverage ☐ Individual Coverage ☐ Medicare ☐ Medicaid

☐ Terminate Coverage due to separation

Dental (Delta Dental) Choose One

☐ Dental DeltaCare USA DHMO

☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

☐ Dental Mid-PPO

☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

☐ Dental PPO

☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

For DeltaCare USA DHMO Only – Primary Dentist Network Facility Name and Number: _____

Note: If no primary dentist is chosen, Delta Dental will assign a provider according to employee's zip code

☐ I Decline Dental Coverage

On the day this coverage begins, if you have dual coverage for you and/or your spouse with another dental carrier please provide the following:

Name of other dental carrier: _____Policyholder Name (Last, First, MI):_____

Policyholder DOB:_____ Policyholder Address:_____

Effective Date of other Policy:_____

☐ Terminate Coverage due to separation

Vision (VSP Vision) Choose Elect of Decline

☐ I elect Vision Coverage

☐ Employee Only ☐ Employee + Family

☐ I Decline Vision Coverage

☐ Terminate Coverage due to separation

New Enrollment or Change Information Provide the following information for any new enrollment or changes

Coverage Selection	Relation	Last Name, First, MI	Sex	Date of Birth	SSN
☐ Medical ☐ Dental ☐ Vision	Spouse/ Domestic Partner*		☐ M ☐ F		
☐ Medical ☐ Dental ☐ Vision	Dependent Child**		☐ M ☐ F		
☐ Medical ☐ Dental ☐ Vision	Dependent Child**		☐ M ☐ F		
☐ Medical ☐ Dental ☐ Vision	Dependent Child**		☐ M ☐ F		
☐ Medical ☐ Dental ☐ Vision	Dependent Child**		☐ M ☐ F		
☐ Medical ☐ Dental ☐ Vision	Dependent Child**		☐ M ☐ F		

*Spousal coverage requires the submission by the employee of a valid marriage license. The establishment of a Domestic Partnership requires the completion and submission by the employee of an Affidavit of Domestic Partnership
**Coverage for children requires the submission by the employee of a copy of the child's birth certificate to verify age.

Premium Only IRS Code Section 125

I understand that if my required contribution to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.
I understand that:

- I cannot change or revoke any of my elections or this compensation redirection agreement at any time of the plan year unless I have a change in family status(including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of spouse, change in my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I take an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage, etc.). **Notification of change must be within 30 days of the qualifying event.**
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year.
- I hereby authorize my employer to reduce my cash compensation by the amount(s) indicated for each pay period during the plan year following the date on which this agreement is signed.

I have examined this agreement and to the best of my knowledge it is true, correct and complete. I have read and understand the IRS Code Section 125 provisions.

X _____ _____

Employee Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Duty to review my pay records.** I understand I have a duty to review my pay records (pay stub, etc.) to confirm that my Employer has properly implemented my salary reduction election. Furthermore, I have a duty to inform the Benefits Department or Payroll Department if I discover any discrepancy between my pay records and this Premium Only IRS Code Section 125 Agreement. I understand that my failure to report any discrepancy may result in a loss of, or reduction in, my benefit elections. I understand should I leave the Company for any reason my coverage will extend until the end of the month and I am financially responsible for all related premium.

Enrollment Signature of Employee	Date
X	