University of Dubuque Benefits Enrollment Form – Medical, Dental, Vision, & Flex

IT IS YOUR RESPONSIBILITY to return to **UD Human Resources**. PLEASE PRINT CLEARLY and SIGN THE BOTTOM OF THIS FORM!

Legal Name (Last) (First) (MI)	Preferred Name	Gender	Medicare Eligible	Social Security Number	Birth Date

Address (Street) (City) (State) (Zip) (Phone Number)	Marital Status: (single, married, divorced)	Hire Date:

Type of Election
☐ **Open Enrollment** ☐ **New Hire** ☐ **Qualifying Event** **Qualifying Event Explanation:** **Effective Date:** **Payroll Cycle** *(circle)*: Monthly / Bi-Weekly

Coverage Information (Please indicate the coverage you are choosing)
Medical (if applicable): ☐Employee Only ☐Employee+1 ☐Family Health Plan Choice (Deductible): ☐Plan A ☐Plan B ☐Plan C ☐Decline Medical Coverage
Dental (if applicable): ☐Employee Only ☐ Family ☐ Decline Dental Coverage
Vision (if applicable): ☐Employee Only ☐ Family ☐ Decline Vision Coverage

If declining any coverage, if you desire to enroll at a later date, your application will be subject to the provisions and limitations of the Summary Plan Description.

Other Medical Coverage: ☐ Yes, attach all pertinent information ☐ No

Section II - ELIGIBLE DEPENDENTS INFORMATION
Note: This application does not guarantee coverage. Common Law spouses are not covered by this plan.

Name (First, MI, Last)	Social Security # / Date of Birth	Sex	Dependent Relation	Other Medical Coverage	Coverage applies to
Spouse			Spouse	☐ Yes, attach all pertinent information ☐ No	☐ Medical ☐ Dental ☐ Vision
Dependent			☐ Natural/Adopted ☐ Step Child	☐ Yes, attach all pertinent information ☐ No	☐ Medical ☐ Dental ☐ Vision
Dependent			☐ Natural/Adopted ☐ Step Child	☐ Yes, attach all pertinent information ☐ No	☐ Medical ☐ Dental ☐ Vision
Dependent			☐ Natural/Adopted ☐ Step Child	☐ Yes, attach all pertinent information ☐ No	☐ Medical ☐ Dental ☐ Vision
Dependent			☐ Natural/Adopted ☐ Step Child	☐ Yes, attach all pertinent information ☐ No	☐ Medical ☐ Dental ☐ Vision
Dependent			☐ Natural/Adopted ☐ Step Child	☐ Yes, attach all pertinent information ☐ No	☐ Medical ☐ Dental ☐ Vision

*If you enroll a spouse or dependent child SISCO will reach out to you to confirm their eligibility to the health plan. Does not pertain to dental or vision coverage.

Flexible Spending Enrollment: ☐I hereby elect to participate in the Flexible Spending Account. Health Care Flex Election Limit: $2,750; Dependent Care Flex Election Limit: $5,000
☐ I Opt Out of Flexible Spending Account

Health Care FSA: Annual Election $_____________ **Dependent Care FSA:** Annual Election $_______________

Direct Deposit: Do you want to elect Direct Deposit for FSA reimbursements? Direct Deposit is a convenient feature that allows reimbursements to be direct deposited into your bank account instead of waiting for a reimbursement check. ☐ Yes, I want to elect Direct Deposit (ATTACH A VOIDED CHECK) ☐ No, I want to receive checks

The above information is complete and true to the best of my knowledge. I understand that falsification by me will allow my employer's group health plan to recover payments made, cancel my coverage, and/or refuse payment of claims. I hereby authorize my employer to deduct required contributions from earnings. I authorize all providers, Facilities and agencies to furnish full information pertaining to all diagnosis and treatments. This consent is subject to revocation at any time. I understand that I cannot revoke or change these elections during the Plan Year unless there is a qualifying "Change in Status" event that affects me or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. As it pertains to Flexible Spending, I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited. I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Signature	Date