

Name: \_\_\_\_\_  
Effective Date of Coverage: \_\_\_\_\_

**\* Indicates Mandatory Benefits Enrollment**

Medical * Choose a plan & coverage level	Employee	Emp + Sp	Emp + Child(ren)	Emp+ Family	Monthly Cost
Allegiance	\$798.00	\$1,169.00	\$1,045.00	\$1,415.00	
Blue Cross Blue Shield	\$748.00	\$1,075.00	\$994.00	\$1,327.00	
Pacific Source	\$837.00	\$1,225.00	\$1,096.00	\$1,484.00	
Enter your Cost here .....					*(A)
Dental * Choose a plan & coverage level	Employee	Emp + Sp	Emp + Child(ren)	Emp+ Family	
Select Plan	\$42.00	\$80.00	\$80.00	\$113.00	
Basic Plan	\$18.00	\$35.00	\$35.00	\$49.00	
Enter your Cost here .....					*(B)
Life Insurance/Accidental Death & Dismemberment *					
Choose one:	\$15,000	\$1.49			
	\$30,000	\$2.97			
	\$48,000	\$4.75			
Enter your Cost here .....					*(C)
Long Term Disability *					
Choose one:	60% of pay/6-month wait	\$5.90			
	66-2/3% of pay/6-month wait	\$11.75			
	66-2/3% of pay/4-month wait	\$14.66			
Enter your Cost here .....					*(D)
Optional Vision	Employee	Emp + Sp	Emp + Child(ren)	Emp+ Family	
Vision Hardware	\$8.05	\$15.19	\$15.99	\$23.45	
Enter your Cost here .....					(E)
<b>Cost .....</b>					<b>Total Lines A-F</b>
<b>Total Monthly Employer Contribution .....</b>					<b>-1054 (G)</b>
<b>Total Monthly before-tax insurance costs .....</b>					<b>Lines G minus F</b>
					<b>(H)</b>

**Below List All Eligible Family Members Enrolled For Medical, Dental, Vision, Optional Supplemental Life and/or Optional AD&D**

Name (Last, First, MI)	Birth Date (Mo/Day/Year)	MANDATORY! Social Security #	Gender		Enrolled In:						Disabled Child	
			M	F	Med.	Den.	Vis.	Basic Life	Opt. Supt. Life	Opt. AD&D		
Employee												
Spouse/ Adult Dependent												
Dependent												
Dependent												
Dependent												
Dependent												

*If you run out of spaces for additional family members, please attach a list to this form.*

**By enrolling dependents, you verify that the dependent(s) meets dependent eligibility requirements and that proof to establish the dependents relationship to you may be required.**

**Flex Mid-Year Elections Changes**

<p>Eligible Employees are permitted to change elections when a qualifying change in status (other than a Plan insurance cost or coverage change occurs). The requested change in elections must be consistent with the change in status; and the request for a change in elections is made within 63 days of the event.</p> <p>Amount of salary reduction for Medical Flexible Spending Account ONLY! You must re-enroll each year to participate in a Flexible Spending Account (NOT automatic!) There are NO exceptions for late enrollment or late submissions. Mid-Year Change for Medical flex must be consistent with event. Medical Flex Account Annual Amount: Minimum of \$120 Maximum \$2,600/Employee If your spouse has a Health Saving Account (HSA) you may have a limited purpose flex for dental and vision only. Please make your election and contact Allegiance to have it setup as a limited purpose account only.</p> <p align="right"><b>Salary Reduction for Medical Flex Monthly Amount</b></p> <p>Dependent Care Annual Amount: Minimum \$120 Maximum \$5,000/Employee</p> <p align="right"><b>Dependent Flex Monthly Amount</b></p> <p>Adoption Assistance Annual Amount: Minimum \$120 Maximum \$13,190 (Total max-NOT annual max)</p> <p align="right"><b>Adoption Assistance Flex Monthly Amount</b></p> <p align="right"><b>Total Monthly Election</b></p>	<p align="center"><b>Flex Spending</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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**2017/2018 Choices Enrollment Mid-Year Change Form**

**Check reason you are completing this form:**

Mid-Year Change

*\*(If you had other coverage within last 63 days, provide Certificate of Credible Coverage)*

*\*\* (No default for Reimbursement Accounts)*

**Employee Information**

Name (Last, First, MI): _____		Social Security Number: _____	HICN #: _____
Address: _____		City, State, Zip: _____	
Phone: Home: ( ) _____	Birth Date: _____		
Work: ( ) _____	<b>Enrollment Status:</b>		
Gender: <input type="checkbox"/> Male	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Claiming an Adult Dependent
<input type="checkbox"/> Female	<i>(Attach Declaration of Adult Dependent Form)</i>		

**Mid-Year Change Information**

To add or delete dependents or make a plan change midyear, (1) check the qualifying event allowing the change and (2) indicate the date of the event below:

**Event allowing dependent addition and some plan changes** (event must have been within the last 63 days): The change in election must be consistent with the event.

- Marriage       Birth of child       Court-ordered custody/support/legal guardianship       Adoption/Pre-adoptive placement

*(If dependent has or had other coverage within last 63 days, provide Certificate of Creditable Coverage.)*

Dependent lost eligibility for other coverage due to (specify): \_\_\_\_\_

The Date of Event is the last date of the other coverage.      Date: \_\_\_\_\_

Dependent transferring to you from another University Plan member due to member's loss of eligibility/retirement.

Specify from whom: \_\_\_\_\_      SS#: \_\_\_\_\_      Campus: \_\_\_\_\_

**Event allowing/requiring dependent deletion and some plan changes:** The change in election must be consistent with the event.

Notify Campus Human Resources ASAP when a covered dependent loses eligibility (within no more than 30 days).

Notice for COBRA continuation within 60 days.

- Death of Dependent       Divorce/legal separation       Change in support order
- Other loss of dependent status due to (specify): \_\_\_\_\_
- You went on leave without pay
- Dependent became eligible for other employer benefits (specify): \_\_\_\_\_
- OTHER (specify): \_\_\_\_\_
- Date of Event: \_\_\_\_\_

**List Your Beneficiaries For Employee Life, and/or AD&D Insurance Beneficiaries**

Primary (Last, First, MI) \_\_\_\_\_ Relationship: \_\_\_\_\_

Contingent (Last, First, MI) \_\_\_\_\_ Relationship: \_\_\_\_\_

If more than one Primary or Contingent beneficiary is to be specified, attach beneficiary information on a separate page. Unless otherwise specified, payment will be shared equally by all primary beneficiaries who survive the Insured; if none, by all contingent beneficiaries who survive. The right to change the beneficiaries is reserved unless otherwise stated.

My Signature indicates that I have read and understand the election for and materials describing options provided by *Choices*, including information contained in the notices section of the *Choices* Enrollment Workbook. My election or waiver of coverage is binding and cannot be revoked or modified (other than as explained in the materials). I understand that my salary will be reduced by the amount designated and that the arrangement for paying premiums with before-tax dollars is intended to meet the IRS requirements. If tax laws change or if this arrangement is deemed not to satisfy IRS requirements, I understand that the tax advantage described may not be available.

I authorize the MUS Plan, and it's contracted Business Associates to obtain, examine or release information needed to coordinate benefits, manage my care, or process claims for myself or my family. I declare that the information furnished on this form is true, correct and complete to the best of my knowledge. This form supersedes all previous forms I have submitted. If I have waived coverage, I understand that satisfactory evidence of insurability may be required to enroll in Life and Long Term Disability and Long Term Care insurance at a later date.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dependent Over 18 Signature: \_\_\_\_\_ Date: \_\_\_\_\_