

# University of Missouri - 2007 Benefits Enrollment Form

Employee Last Name		Employee First Name		MI	Employee ID (not SSN)	Social Security Number
Street					Hire Date	Date of Birth
City	State	Zip	Home Phone		Work Phone	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

W This form must be completed and returned within 30 days of your date of hire or your benefit eligibility date. If it is not returned within 30 days, you will not be eligible to enroll until the next Annual Enrollment period for a coverage effective date of the 1<sup>st</sup> of January following the enrollment period.

W Make your benefit selections (section I) and complete the *Other Medical Insurance Coverage* (section II).

- Your contributions for the medical, dental, vision, life insurance (2 x salary), and the long-term disability (Option B) are deducted on a before-tax basis, unless you are exempt from federal or state taxes or specifically elect otherwise.
- After the initial enrollment, if you want to change how you pay your share of the benefit costs from an after-tax to a before-tax basis, or vice versa, you can only do so during the annual enrollment change period.

W Complete the *Dependent Information* (section III) and provide the required proof of relationship within 90 days from date of coverage if you are covering dependents. Complete *Employed Relatives* (Section IV).

W Complete the *University Beneficiary Designation* form for your Basic Life Plan, Accidental Death & Dismemberment, and/or Pre-Retirement Death Benefits.

W Read, sign and date the *Authorization and Acknowledgements* (section V). Return both forms to your Campus Benefit Representative (CBR). **Please be sure to make a copy for yourself.**

## I. ENROLLMENT OPTIONS:

Pre-tax unless this box is checked for an after tax contribution

### Medical

	Employee Only	Employee + Spouse	Employee + Child/ren	Employee + Family
UM Choice Plus POS Plan	<input type="checkbox"/> (13) \$98.94	<input type="checkbox"/> (14) \$218.64	<input type="checkbox"/> (15) \$167.16	<input type="checkbox"/> (16) \$285.24
Catastrophic Medical Plan	<input type="checkbox"/> (01) \$43.94	<input type="checkbox"/> (02) \$102.92	<input type="checkbox"/> (03) \$61.50	<input type="checkbox"/> (04) \$123.50
Humana HMO (Kansas City only) <small>(Separate PCP Selection form must be completed)</small>	<input type="checkbox"/> (17) \$137.32	<input type="checkbox"/> (18) \$303.58	<input type="checkbox"/> (19) \$232.22	<input type="checkbox"/> (20) \$394.66
Decline	<input type="checkbox"/> (W) waive			

Pre-tax unless this box is checked for an after tax contribution

### Dental

	Employee Only	Employee + Spouse	Employee + Child/ren	Employee + Family
Dental Plan	<input type="checkbox"/> (01) \$13.64	<input type="checkbox"/> (02) \$27.30	<input type="checkbox"/> (03) \$33.12	<input type="checkbox"/> (04) \$46.76
Decline	<input type="checkbox"/> (W) waive			

Pre-tax unless this box is checked for an after tax contribution

### Vision (Effective 1/1/07)

	Employee Only	Employee + Spouse	Employee + Child/ren	Employee + Family
Vision Plan	<input type="checkbox"/> (01) \$6.00	<input type="checkbox"/> (02) \$12.00	<input type="checkbox"/> (03) \$13.00	<input type="checkbox"/> (04) \$20.60
Decline	<input type="checkbox"/> (W) waive			

Option B is pre-tax unless this box is checked for an after tax contribution

### Basic Life

	Option A (1 x base salary & age graded)	Option B (2 x base salary & age graded)
Basic Life Insurance	<input type="checkbox"/> (01) \$0.00	<input type="checkbox"/> (02) \$.044 per \$1000 of coverage
Decline	<input type="checkbox"/> (W) waive	

After Tax Contribution

### AD&D

	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000
AD&D - Self	<input type="checkbox"/> (01) \$.53	<input type="checkbox"/> (02) \$1.05	<input type="checkbox"/> (03) \$1.58	<input type="checkbox"/> (04) \$2.10	<input type="checkbox"/> (05) \$2.63	<input type="checkbox"/> (06) \$3.15
AD&D - Family	<input type="checkbox"/> (07) \$.73	<input type="checkbox"/> (08) \$1.45	<input type="checkbox"/> (09) \$2.18	<input type="checkbox"/> (10) \$2.90	<input type="checkbox"/> (11) \$3.63	<input type="checkbox"/> (12) \$4.35
Decline	<input type="checkbox"/> (W) waive					

After Tax Contribution (rates will vary based on age)

### Supplemental Life\*

Supplemental life options are 1, 2 or 3 times your annual base salary. You may elect or increase your supplemental life coverage. Please request the applicable form from your Campus Benefit Representative.
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After Tax Contribution (rates will vary based on age)

### Spouse Life

	\$10,000	\$20,000	\$30,000*	\$40,000*	\$50,000*
Spouse	<input type="checkbox"/> (01)	<input type="checkbox"/> (02)	<input type="checkbox"/> (03)	<input type="checkbox"/> (04)	<input type="checkbox"/> (05)
Decline	<input type="checkbox"/> (W) waive				

After Tax Contribution

### Dependent Life Child/ren

	\$5,000	\$10,000*	\$15,000*	\$20,000*	\$25,000*
Dependent Child/ren	<input type="checkbox"/> (01) \$0.39	<input type="checkbox"/> (02) \$0.78	<input type="checkbox"/> (03) \$1.17	<input type="checkbox"/> (04) \$1.56	<input type="checkbox"/> (05) \$1.95
Decline	<input type="checkbox"/> (W) waive				

\* Evidence of insurability is required. Applicable forms may be obtained from your Campus Benefits Representative.

Option B is pre-tax unless this box is checked for an after tax contribution

**Long Term Disability**

Option A	Option B*
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Long Term Disability Decline

<input type="checkbox"/> (01) \$0.00	<input type="checkbox"/> (02) \$.21 per \$100 of monthly income
<input type="checkbox"/> (W) waive	

After Tax Contribution

**Long Term Care**

For information and enrollment, contact MetLife at 800-438-6388 (TDD: 800-638-1004)
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\* Evidence of insurability is required. Applicable forms may be obtained from your Campus Benefits Representative.

**II. OTHER MEDICAL COVERAGE:**

Medical Insurance Coverage - complete only if applicable, use additional page if necessary			
Name of Insured With Medicare Coverage		Is other coverage Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare ID No.
If not Medicare Provide:	Policy/Group Number	Effective Date	Name of Employer
Name of Other Insurance:		Address:	

**III. DEPENDENT INFORMATION:**

Dependent/Spouse Name	Relationship	Gender	Date of Birth	Social Security Number	Coverage		
					Medical	Dental	Vision

**IV. EMPLOYED RELATIVES:**

Do you have a spouse, parent or child who works for the University of Missouri?  Yes  No

If you answered yes, please indicate the name: \_\_\_\_\_

**V. AUTHORIZATION AND ACKNOWLEDGEMENTS:**

**Election Authorization**

*I hereby make the above elections and I authorize the University of Missouri to deduct/redirect the appropriate amounts from my pay for the coverages elected. (I also hereby authorize the appropriate providers to release any documentation necessary to pay my or my dependents' claims.)*

*I understand it is my responsibility to inform the University Benefits office of desired changes in coverage and/or changes in my family status or personal information that affect my benefit coverage or eligibility by completing an Enrollment Change form within 31 days of the event.*

**Acknowledgements:**

*1. I acknowledge, that in the event that I or any of my dependent/s become ineligible for coverage under the Plan, applicable contribution refunds will be made, provided the Plan receives notification of an enrollment change within 31 days of a Qualifying Event which results in a reduction of contributions. If I fail to provide notice of an enrollment change within 31 days of a Qualifying Event which would result in a reduction of contributions, a refund of the contribution overcharge, not to exceed the first two ineligible months' contribution rates, will be made to me. Any claims paid on behalf of an ineligible individual must be reimbursed to the Plan by me before a contribution refund will be made.*

*2. I acknowledge that I am providing principal support for any unmarried child dependent/s listed above, who are ages 19 through the age of 24, are receiving benefit coverage under a University of Missouri medical, dental, and/or vision health plan, and if age 23 through age 24 are full-time students attending an accredited school,*

\_\_\_\_\_  
Employee ID or SSN

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

For Office Use Only	UHC Group/Dept. #	Hire/Eligibility Date	Effective Date	Initials
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