

University of Missouri - 2007 Benefits Enrollment Change 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 Changes to your medical, dental, or vision enrollment elections, at a time other than the Annual Enrollment change period, require that you have a change in family status. If you have one of the changes listed under Family Status Change (section I), complete sections I, II, III, and IV.

W Provide the required proof of relationship documentation within 90 days from the date of the change.

W Changes to other benefit elections may have specific requirements or restrictions and must be consistent with the Family Status change reason. Please contact your Campus Benefit Representative (CBR) for details on changes to benefits other than medical, dental, or vision.

W Read, sign and date the *Authorization and Acknowledgements* (section IV). Return this form to your CBR. **Please be sure to make a copy for yourself.**

I. FAMILY STATUS CHANGE: Effective Date: _____

<input type="checkbox"/> Add coverage due to: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Spouse loses other medical coverage <input type="checkbox"/> Spouse's employer discontinues coverage or significant change in coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Existing child becomes eligible (court order/return to college, etc.) <input type="checkbox"/> Child/ren lose other coverage <input type="checkbox"/> Child/ren of new spouse (must live with employee)	<input type="checkbox"/> Cancel Coverage due to: <input type="checkbox"/> Death <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Dependent becomes ineligible <input type="checkbox"/> Spouse obtains other health coverage
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II. DEPENDENT INFORMATION: Complete the following information for any dependent(s) to be added or canceled.

Dependent/Spouse Name	Relationship	Gender	Date of Birth	Social Security Number

III. ENROLLMENT OPTIONS: Complete **only** the enrollment options that will be affected by this change.

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

Medical

Employee Only	Employee + Spouse	Employee + Child/ren	Employee + Family
<input type="checkbox"/> (13) \$98.94	<input type="checkbox"/> (14) \$218.64	<input type="checkbox"/> (15) \$167.16	<input type="checkbox"/> (16) \$285.24
<input type="checkbox"/> (01) \$43.94	<input type="checkbox"/> (02) \$102.92	<input type="checkbox"/> (03) \$61.50	<input type="checkbox"/> (04) \$123.50
<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
<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

Employee Only	Employee + Spouse	Employee + Child/ren	Employee + Family
<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)
<input type="checkbox"/> (01) \$0.00	<input type="checkbox"/> (02) \$.044 per \$1 000 of coverage
Decline <input type="checkbox"/> (W) waive	

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

	After Tax Contribution					
	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000
AD&D						
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					

Supplemental Life*

After Tax Contribution

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.

Spouse Life

After Tax Contribution (rates will vary based on age)

	\$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				

Dependent Life Child/ren

After Tax Contribution

	\$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				

Long Term Disability

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

	Option A	Option B*
Long Term Disability	<input type="checkbox"/> (01) \$0.00	<input type="checkbox"/> (02) \$.21 per \$100 of monthly income
Decline	<input type="checkbox"/> (W) waive	

• Evidence of insurability is required. Applicable forms may be obtained from your Campus Benefit Representative.

IV. 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:

- 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.*
- 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