University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST. LOUIS

2024 Benefits Enrollment Form

☐ Check box if this is a revised enrollment ☐ Check box if you have a J1 VISA.

Employee Last Name	Employee First Name	MI	Employee ID (not SSN)	
Street			Hire Date	Date of Birth
City	State / ZIP / Home Phone		Work Phone	Gender

Benefit Election Instructions

- This form must be completed and returned within 31 days of your date of hire or your benefit eligibility date. If it is not returned within 31 days, you will not be eligible to enroll until the next Annual Enrollment period for a coverage effective date of January 1 following the enrollment period.
- Complete Section I, *Dependent Information*, and provide the required proof of relationship within 31 days from date of coverage if you are covering dependents.
- Make your benefit selections in Section II, *Enrollment Options*.
  - Your contributions for the Medical, Dental, Vision, Basic Life (Option B) and Long-Term Disability (Buy-up Plan) insurance plans 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.
- Complete Section III, *Beneficiary Designation Form,* if applicable, for your Basic Life, Additional Life and Accidental Death and Dismemberment insurance plans.
- Read, sign and date Section IV, *Authorization and Acknowledgements*, before returning this form to your campus contact or the HR Service Center (HRSC). Campus contact and HRSC information is listed on the last page of this document.

I. Dependent Information

Complete the following information for any dependent(s) to be added or cancelled. Changes should also be reflected in Section II.

Dependent/ Spouse Name	**Relationship (Spouse/SAD*** or Child)**	**Gender (M/F)**	**Birth Date (MM/DD/YY)**	**Social Security Number**	**ADD****				**REMOVE**			
					Medical	Dental	Vision	Life	Medical	Dental	Vision	Life

*** If you enroll a Sponsored Adult Dependent (SAD) on your plan, you will also need to complete an Affirmation.

****If you are adding a dependent to your insurance, you will be required to provide Proof of Relationship (POR).

II. Enrollment Options

Medical Insurance

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

	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Healthy Savings Plan**	☐ (01) $62.00	☐ (02) $177.00	☐ (04) $156.00	☐ (05) $303.00
Custom Network Plan (Columbia area)	☐ (25) $92.00	☐ (26) $259.00	☐ (28) $242.00	☐ (29) $437.00
Custom Network Plan (St. Louis area)	☐ (73) $92.00	☐ (74) $259.00	☐ (76) $242.00	☐ (77) $437.00
PPO Plan	☐ (13) $187.00	☐ (14) $457.00	☐ (16) $435.00	☐ (17) $735.00
Tiered PPO Plan (for Kansas City and Rolla areas)	☐ (85) $187.00	☐ (86) $457.00	☐ (87) $435.00	☐ (88) $735.00

**If you enroll in the Healthy Savings Plan, you will also need to complete the HSA Enrollment Form.
Note: The Healthy Savings Plan is not an eligible plan for employees who have a J1 VISA.

Waive medical coverage
Decline ☐ (W) waive

Dental Insurance

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

Dental	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Dental Base Plan	☐ (01) $15.53	☐ (02) $31.05	☐ (03) $37.68	☐ (04) $53.21
Dental Buy-up Plan	☐ (13) $26.18	☐ (14) $52.30	☐ (15) $82.85	☐ (16) $111.04
Decline	☐ (W) waive			

Vision Insurance

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

Vision	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
	☐ (01) $5.06	☐ (02) $10.08	☐ (03) $11.00	☐ (04) $17.41
Decline	☐ (W) waive			

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Disability and Life Insurance

Basic Life

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

Option A (1x annual base salary & age graded)	Option B (2x annual base salary & age graded)*
☐ (01) $0.00	☐ (02) $0.022 per $1,000 of coverage

Accidental Death and Dismemberment

After-tax contribution

	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000
AD&D – Self	☐(01) $0.35	☐(02) $0.70	☐(03) $1.05	☐(04) $1.40	☐(05) $1.75	☐(06) $2.10
AD&D – Family	☐(07) $0.50	☐(08) $1.00	☐(09) $1.50	☐(10) $2.00	☐(11) $2.50	☐(12) $3.00
Decline	☐(W) Waive					

Dependent Life - Spouse/ Sponsored Adult Dependent

After-tax contribution (rates will vary based on age)

$10,000	$20,000	$30,000*	$40,000*	$50,000*	$60,000*	$70,000*	$80,000*	$90,000*	$100,000*
☐ (01)	☐ (02)	☐ (03)	☐ (04)	☐ (05)	☐ (06)	☐ (07)	☐ (08)	☐ (09)	☐ (10)

Decline ☐ Waive

*Statement of Health is required for all new elections over $20,000. Learn more at umurl.us/life.

Dependent Life-Child(ren)

After-tax Contribution (rates will vary based on age)

$5,000	$10,000	$15,000	$20,000	$25,000
☐ (01) $0.32	☐ (02) $0.64	☐ (03) $0.96	☐ (04) $1.28	☐ (05) $1.60

Decline ☐ (W) waive

Additional Life

After-tax contribution (rates will vary based on age).

1X annual base salary	2X annual base salary*	3X annual base salary*	4X annual base salary*	5X annual base salary*	6X annual base salary*	7X annual base salary*	8X annual base salary*
☐ (01)	☐ (02)	☐ (03)	☐ (04)	☐ (05)	☐ (06)	☐ (07)	☐ (08)

Decline ☐ Waive

*Statement of Health is required for amounts over 1x annual base salary. Learn more at umurl.us/life.

Long-Term Disability

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

Core Plan (Option A)	Buy-up Plan (Option B)
☐ (01) $0.00	☐ (02) $0.14 per $100 of monthly income

Short-Term Disability

Option B is pre-tax contribution

Core Plan (Option A)	Buy-up Plan (Option B)
	☐ (02) $0.14 per $100 of monthly income

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III. Beneficiary Designation

Complete this section only if you wish to make a change to your current beneficiary designation.

If you're naming only one primary beneficiary, put 100% in the percent column. If you're naming more than one primary beneficiary, you must indicate what percentage each is to receive. The total **MUST** equal 100%. The same applies for your contingent beneficiaries.

☐ I do not want to change my beneficiaries at this time.

Basic Life Insurance Plan Beneficiar(y/ies)

Primary

Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)

Contingent

Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)

Additional Life Insurance Plan Beneficiar(y/ies)

Primary ☐ Beneficiar(y/ies) same as Basic Life Insurance Plan

Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)

Contingent

Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)

Accidental Death & Dismemberment Insurance Plan Beneficiar(y/ies)

Primary ☐ Beneficiar(y/ies) same as Basic Life Insurance Plan

Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)

Contingent

Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)
Name	Address	Relationship	Social Security Number	Share (%)

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IV. Authorization and Acknowledgements

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 acknowledge that in the event that I or any of my dependent/s become ineligible for coverage under the Plan, it is my responsibility to inform the University of Missouri System's Office of Human Resources of desired changes in coverage and/or changes in my family status or personal information that affects my benefit coverage or eligibility by completing an enrollment change form within 31 days of the event. (I also understand that any claims paid on behalf of an ineligible individual must be reimbursed to the Plan by me.)

I acknowledge and agree that this document may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. "Electronic signature" shall include faxed versions of an original signature, electronically scanned and transmitted versions of an original signature, and typed signature in a fillable form or typed signature via Adobe Pro.

_____	_____	_____
Employee ID	**Signature of Employee**	**Date**

Availability of Summary Health Information

As an employee of University of Missouri System, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC, along with a uniform glossary of terms commonly used in health care coverage, is available on the web at: http://umurl.us/SBC. Paper copies are also available, free of charge, by calling the HR Service Center at 1-800-488-5288.

Campus Contact Information

HR Service Center
Phone: (573) 882-2146
Fax: (573) 882-9603
hrservicecenter@umsystem.edu

Columbia (includes Hospital and System)
Phone: (573) 882-2146
Fax: (573) 882-9603
hrservicecenter@umsystem.edu

Kansas City
Phone (816) 235-1621
Fax: (816) 235-5515
benefits@umkc.edu

Rolla
Phone (573) 341-4241
Fax: (573) 341-4984
benefits@mst.edu

St. Louis
Phone (573) 882-2146
Fax: (573) 882-9603
umslbenefits@umsl.edu