University Health

Employee ID #

2021 Benefit Change Form

Last Name	First Name	Social Security Number	Home/Work Phone	Gender: ❑Male ❑Female
Home Address:	City State Zip		Email:	

Qualifying Event: Submit completed forms and proper supporting documentation to UHS.Benefits@uhs-sa.com. Your change will not be processed without proper documentation **attached** or if you fail to notify Human Resource within 31 days of your qualifying event.

❑Marriage/Divorce	❑Change in spouse's employment status	❑Change in dependent's status
❑Birth/Adoption/New Legal Guardianship	❑Change in employee's employment status	❑Other Reason:

***Medical Enrollment**
Changing Coverage to:

❑Employee Only ❑Employee & Spouse/Domestic Partner

❑University Family Care Plan ❑Employee & Child(ren) ❑Employee & Family ❑Decline Coverage

***Dental Enrollment**
Changing Coverage to:

❑Delta Dental DHMO 13B Plan ❑Delta Dental PPO Low Plan ❑Delta Dental PPO High Plan

❑Employee Only ❑Employee & Spouse/Domestic Partner

❑Employee & Child(ren) ❑Employee & Family ❑Decline Coverage

***Vision Enrollment**
Changing Coverage to

❑Employee Only ❑Employee & Spouse/Domestic Partner

❑EyeMed ❑Employee & Child(ren) ❑Employee & Family ❑Decline Coverage

***Flexible Spending**

❑Decline

❑Medical Reimbursement Annual Expenses $_____ ($100 Minimum)

❑Dependent Care Reimbursement Annual Expenses $_____ ($100 Minimum)

Dependent Life Insurance
(must be enrolled in Supplemental Life Insurance)

❑$ 10,000 Spouse / $ 5,000 Child(ren)
❑$ 20,000 Spouse / $ 10,000 Child(ren)
❑$ 30,000 Spouse / $ 15,000 Child(ren)
❑$ 40,000 Spouse / $ 20,000 Child(ren)

❑Continue Existing
❑Decline

Name **(Only add new dependents)**	Relationship	DOB	Gender (M/F)	Primary Care Physician No.	Primary Dental Provider (DHMO only)	Social Security Number	Medical (Y/N)	Dental (Y/N)	Vision (Y/N)	Dep Life (Y/N)
	Self									
	Spouse									
	Child									
	Child									
	Child									
	Child									
	Child									

Assign Beneficiaries for the following Plans: (please print clearly)

Basic Life Insurance Beneficiary		%	Relationship	Date of Birth	Address	Phone Number
	Primary					
	Primary					
	Primary					
	Contingent					
	Contingent					
Supplemental Life Insurance Beneficiary		**%**	**Relationship**	**Date of Birth**	**Address**	**Phone Number**
	Primary					
	Primary					
	Primary					
	Contingent					
	Contingent					
Pension Beneficiary		**%**	**Relationship**	**Date of Birth**	**Address**	**Phone Number**
	Primary					
	Primary					
	Contingent					
	Contingent					

Aflac Cancer **Basic Plan Low Plan (Includes children)**	**❑$10,000**	**❑$20,000**	**❑$30,000**	**❑$40,000**	**❑$50,000**
❑Employee Only	$6.23	$11.79	$17.35	$22.91	$28.47
❑Employee & Spouse/Domestic Partner	$12.46	$23.58	$34.70	$45.82	$56.94
Enhanced High Plan (Includes children)	**❑$10,000**	**❑$20,000**	**❑$30,000**	**❑$40,000**	**❑$50,000**
❑Employee Only	$8.55	$16.47	$24.38	$32.30	$40.21
❑Employee & Spouse/Domestic Partner	$17.10	$32.94	$48.76	$64.60	$80.42

I certify that I am, and each of my enrolled dependents is, eligible to participate in plans elected for us on this form, as eligibility is defined in each plan. **I understand that my benefit elections cannot be changed or revoked before the next UHS open enrollment unless there is appropriate status change (such as change in legal marital status, number of dependents, employment status, dependent eligibility, change of residence, or COBRA) or other permitted event such as court order, HIPPA enrollment rights, Medicare/Medicaid eligibility, or significant cost or coverage change. Changes must be requested and documented within 31 days of the event.**

AUTHORIZATION: I hereby authorize my licensed physician, hospital, pharmacy, clinic, health care facility, insurance company, employer, or organization to release to the University Health System or its agents any information regarding me or my enrolled family members' medical history, treatment, and/or disability that is reasonably necessary for the purpose of utilization review, coordination of benefits, or payment of a claim. The authorization shall cease to be effective at such time when my coverage under the Plan terminates. In the event that I have any outstanding claims at time of termination, the authorization will continue to apply until all the claims have been settled. I understand that UHS will automatically deduct from my wages the amount of any co-pays I or my dependents incur as a result of receiving medical services or supplies from UHS under any UHS-sponsored group health plan, and I give my authorization for such deductions. In addition, in the case of coverage I have elected under any plan indicated with *above, I authorize payment of the applicable premiums by means of payroll deduction on a pre-tax basis. For all other plans, I authorize payment of the applicable premiums by means of payroll deduction on an after-tax basis. I hereby attest that the statements made by me are true, and I understand that any material Misstatements may be used to contest the validity of my benefits. **˜Proof of dependent status must be submitted for dependents in order to maintain coverage**.

Employee Signature:	Date:

Office Use Only: Effective Date:	Initials:	Date Keyed: