University Health

Employee ID:

Benefits Election Form

Last Name	First Name	MI	Social Security Number	Date of Birth	Gender:

Home Address	City	State	Zip	Home Phone	Work Phone

Medical Enrollment: ❑University Family Care Plan ❑Employee ❑Employee & Spouse/Domestic Partner ❑Employee & Child(ren) ❑Employee & Family ❑Continue Existing Coverage ❑ Decline **(Submit proof of other coverage)**

Dental Enrollment: ❑Delta Dental DHMO ❑Delta Dental DPO - Low Plan ❑Delta Dental DPO - High Plan ❑Employee ❑Employee & Spouse/Domestic Partner ❑Employee & Child(ren) ❑Employee & Family ❑Continue Existing Coverage ❑ Decline

Vision Enrollment: ❑EyeMed ❑Employee ❑Employee & Spouse/Domestic Partner ❑Employee & Child(ren) ❑Employee & Family ❑Continue Existing Coverage ❑ Decline

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

***Dependent documentation must be attached or you may send it by e-mail to uhs.benefits@uhs-sa.com or fax to 210-358-4765.**

Basic Term Life Insurance: ❑$25,000 at No Charge to eligible employees

*Combined Basic and Supplemental Life Insurance cannot exceed $1,000,000

Supplemental Term Life Insurance:

❑1X Annual Earnings ❑2X Annual Earnings ❑3X Annual Earnings ❑4X Annual Earnings ❑5X Annual Earnings ❑Decline

*Over $500,000 requires completion of a Health Questionnaire

Dependent Life Term Insurance: (Employees must enroll in supplemental life to elect dependent life coverage)

❑$10,000 Spouse/$5,000 Child ❑$20,000 Spouse/$10,000 Child ❑$30,000 Spouse/$15,000 Child ❑Decline

❑$40,000 Spouse/$20,000 Child ❑$50,000 Spouse/$25,000 Child

*Dependent Life Insurance may not exceed 100% of the insured's combined amount of Basic and Supplemental Life Insurance

Flexible Spending: ❑Yes, I would like to enroll ❑Medical Reimbursement ($100 Minimum) Annual Expenses: $ _____

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

*Please note that dependent care reimbursement is limited to day care expenses, including day camp & preschool, for dependents under age 13 or any age if incapable of self care. Please reference Benefit Guide for complete eligibility details.

Short-Term Disability: ❑40% of weekly salary ❑50% of weekly salary ❑60% of weekly salary ❑Decline

Long Term Disability: ❑50% of monthly salary ❑60% of monthly salary ❑Decline

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

Assign Beneficiaries for the following plans below: please print clearly

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

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 de-

Employee Signature:		Date:	
OFFICE USE ONLY: Status	DOH:	Effective Date:	Initials: Date Keyed: