ANNUAL BENEFIT ENROLLMENT FORM —Elections / Changes

Complete All Sections with Printed Information

Plan Year Effective: 01/01/2025

❶ Employee Information *(please print)*

Last Name	First Name	M.I.	Gender: ❑M / ❑F / ❑X	Banner ID:
Mailing Address			Social Security Number	Date of Birth
City	State	Zip	Phone ❑ Cell ❑ Home	Date Employed
Employer Name **UTICA UNIVERSITY**	Marital Status ❑Married ❑Single		EMAIL ADDRESS—***REQUIRED FOR FSA ENROLLMENT***	

❷ Benefit Election

Medical Monthly Rates ❑ *Waive Coverage*

	BluePPO J	HealthyBlue	SimplyBlue
Single	❑ $233.07	❑ $135.83	❑ $50.00
Emp+Spouse	❑ $466.14	❑ $271.65	❑ $128.82
Emp+Child/ren	❑ $442.84	❑ $258.07	❑ $122.38
Family	❑ $643.02	❑ $374.73	❑ $177.71

Dental-Monthly Rate ❑ *Waive Coverage*

	HIGH Plan	LOW Plan
Single	❑ $35.92	❑ $22.84
Employee+1	❑ $62.68	❑ $37.15
Family	❑ $115.98	❑ $63.50

Voluntary Insurances ❑ *Waive Enrollment*

❑ Term Life Insurance-Unum

❑ AD&D Insurance-Prudential

Flexible Spending Accounts (FSAs) ❑ *Waive Enrollment*
Insert Annual Election / HR determines amount per pay

Health Care FSA *2025 IRS Maximum $3200*	$
Limited Purpose Health Care FSA *2025 IRS Maximum $3200*	$
Dependent Care FSA *2025 IRS Maximum $5,000*	$

Vision-Monthly Rate ❑ *Waive Coverage*

Single	❑ $6.40
Employee+1	❑ $11.51
Family	❑ $17.92

Dependent Coverage Information

(Circle elections and print information)

A=Add Coverage

T=Terminate Coverage

***Relationship Code:** *Dependents eligible for coverage may not qualify for all Plan benefits – please check federal IRS requirements, especially before submitting claims.*

O= Legal spouse **C**=Child **N**=Over Age Child with Disabilities
D=Domestic partner **K**= Domestic partner's child **W**=Legal ward

Medical	Dental	Vision	Dependent	Name *(First and Last)*	Social Security #	Date of Birth	Code* *See above*	Gender	Post High School Student
A T	A T	A T	❑Spouse ❑ Dom Partner					❑M ❑F	
A T	A T	A T	Child					❑M ❑F	❑ Y ❑ N
A T	A T	A T	Child					❑M ❑F	❑ Y ❑ N
A T	A T	A T	Child					❑M ❑F	❑ Y ❑ N
A T	A T	A T	Child					❑M ❑F	❑ Y ❑ N
A T	A T	A T	Child					❑M ❑F	❑ Y ❑ N

❸ Medical Waiver Buyout

For those employees who have alternative health insurance coverage, Utica University will make a once a year annual lump-sum payment, payable in December of each year, to employees who have waived Utica University health insurance plan for eleven consecutive months (January through November) prior to date of payment. *No prorated payments will be made.*

Proof of alternate insurance is required. Please complete dependent coverage information and attach a copy of your insurance card.

❹ Group Life and AD&D Beneficiary Form *(please print)*

Primary Beneficiary	% of Benefit	Social Security #	Relationship
Primary Beneficiary	% of Benefit	Social Security #	Relationship
Primary Beneficiary	% of Benefit	Social Security #	Relationship
Contingent Beneficiary (used only if the beneficiaries above are deceased)		Social Security #	
Employee/Insured Signature		Date Signed	

Authorization Continued on the back

I understand that I cannot change my election until the next Open Enrollment period, unless a qualified change in status occurs, as defined by IRC §125. Furthermore I understand that I am liable (not my employer) for any unpaid medical expenses.

Name *(Last, First)*: _____

❺ **Authorization**	***My signature indicates acceptance of the terms and conditions below:*** *I acknowledge that I have received and accept the terms of the benefits-related materials provided to me, including any Summary Plan Descriptions, Summary of Material Modifications, Evidence of Coverage, and Summary of Benefits and Coverage.* *I authorize my employer to deduct any required premiums/contributions from my wages for the benefits I have elected and, where applicable, for such required premiums/contributions to be taken from my wages on a pretax basis.* *I understand that my elections are required to be made for the entire plan year and cannot be changed except in limited circumstances as permitted under the Internal Revenue Code ("Code") and/or the terms of the applicable benefit plan.* *I further understand that my dependent(s) must qualify as a tax dependent under applicable provisions of the Code, and that I am obligated to timely inform my employer if my dependents are not/no longer eligible as my tax dependents, or if there is any other life event that would impact my dependent's eligibility under the terms of the plans in which I am enrolling.* *Finally, I certify the information on my annual benefit enrollment forms is true and correct to the best of my knowledge and that they will be relied on by my employer.* *Any misstatements, misrepresentations, fraud or omissions may result in my and/or my dependent's denial of prior or outstanding claims and/or termination from the benefit plan, and any such termination may be retroactive as permitted by applicable law. Further, any misstatement, misrepresentations, fraud, or omissions may result in disciplinary action against me by my employer, legal action, and/or criminal prosecution.* **Employee Signature:** _____ **Date:** _____
IMPORTANT DEADLINE	Employees MUST submit the required enrollment forms and applications by the benefit effective date, as defined by the employer's benefit plan documents; employees who fail to do so waive their right for initial benefit enrollment. The next opportunity to enroll in benefits is during Open Enrollment for benefits effective January 1, 2025, or in the event of an IRS qualifying change in status.

EMPLOYER SECTION	❑**NEW HIRE**	❑**RE-HIRE**	❑**STATUS CHANGE**	❑**TERM**
Date of Hire: _____	Re-Hire Date: _____		Annual Salary: _____	
Job Title: _____	Hours / Week: _____		Department/Location: _____	
Qualifying Event: _____	Effective Date: _____		Benefit Effective Date: _____	

Qualifying Event *(describe reason for mid-year change to elections i.e.: name change due to marriage etc.)*

COBRA Event: _____ Date of COBRA Event: _____ Last Payroll Deduction: _____

Select reason below for COBRA offering —Coverage continues through: ❑term date ❑end of month

❑Voluntary Termination ❑Involuntary Termination ❑Death ❑Reduced Hours
❑Ineligible Dependent ❑Divorce/Separation ❑Loss of Coverage

Employer Initials: _____
Date: _____