Benefit Enrollment/Change Form

Human Resources
Weinstein Hall
28 Westhampton Way
University of Richmond, VA 23173
(804) 289-8747 Fax: (804) 287-1282
urhr@richmond.edu
hr.richmond.edu

Last Name: _____ **First Name:**_____ **Middle Initial:** _____
UR ID#: _____ **Effective Date:** _____ **(requires approval by HR)** **Paid: Monthly** ○ **Bi-weekly** ○

Form Submission Reason

○ New Hire* ○ Marital Change ○ Birth/Adopaon ○ Ineligible Dependent ○ Employment/Benefit Change ○ Beneficiary Change ○ Other- Please Explain:_____	Date of Event/ Hire Date: _____

** It is the responsibility of the employee to complete an enrollment application for one of the University's health insurance plans or waive coverage no later than 31 calendar days after his or her employment start date. If an employee fails to comply with this requirement, the University will understand this to mean the employee is declining health insurance coverage and may not enroll until Open Enrollment unless there is an eligible status change.*

Qualifying Event

Employees have 31 days from the qualifying event date to add or remove themselves, a dependent, spouse, or same-sex domestic partner from coverage. Supporting or additional documentation may be required. Qualifying status change reasons and dependent eligibility details are located at http://hr.richmond.edu/benefits/insurance/medical-plans/pdf/plan-document.pdf.

Medical Plan: Cigna

○ High Deductible Health Plan (HDHP)	○ Traditional	Waive Coverage: **Proof of other coverage required** ○ 5 days' vacation - Pro-rated ○ $500 (only option for faculty) - Pro-rated

Coverage Level

○ Employee Only	○ Employee plus Child	○ Employee plus Spouse/SSDP	○ Employee plus Children	○ Employee plus Family

Dental Plan: Anthem

○ Enroll	○ Decline

Coverage Level

○ Employee Only	○ Employee plus Child	○ Employee plus Spouse/SSDP	○ Employee plus Family

Vision Plan: UniView Vision

○ Enroll	○ Decline

Coverage Level

○ Employee Only	○ Employee plus Child	○ Employee plus Spouse/SSDP	○ Employee plus Children	○ Employee plus Family

Dependent Information

Dependent Children may remain on health/dental/vision until Dec. 31 of the year they turn 26. Please list additional dependents on attached page.

Add/ Remove	Name: Last, First, M.I.	SSN	Relation	Legally Married (Y/N)	DOB	Gender (M/F)	**Medical**	PCP Name	**Dental**	**Vision**
Select			Self				○		○	○
Select			Spouse SSDP				○		○	○
Select			Child				○		○	○
Select			Child				○		○	○
Select			Child				○		○	○
Select			Child				○		○	○
Select			Child				○		○	○

Legal Resources- Must complete enrollment online at www.legalresources.com/enroll_now **Company ID:** 264 **Password:** nhlegal

○ Enroll (NEW HIRES ONLY)- Must complete online enrollment above	○ Decline

Flexible Spending- You may not elect this if enrolled in the HDHP. Flexible Spending Accounts must be re-elected every year or your FSA account will be termed December 31st. Complete enrollment form and submit to HR - http://hr.richmond.edu/forms/fsa-enrollment-form.pdf

Medical Flexible Spending- ($2,550 per person maximum)	○ Enroll	**Annual amount:** _____
	○ Decline	
Dependent Care Flexible Spending- ($5,000 household maximum)	○ Enroll	**Annual amount:** _____
	○ Decline	

Health Savings Account- Only eligible when enrolled in HDHP plan, cannot be on another health plan, Medicare or have a FSA. Must complete enrollment online at http://hr.richmond.edu/benefits/insurance/medical-plans/pdf/hsa-enrollment-brochure.pdf.

○ Enroll - Must complete enrollment form above	**Amount per pay period:**_____	○ Decline

Voluntary Life Insurance- Complete enrollment form and submit to HR http://hr.richmond.edu/benefits/common/insurance-application.pdf

Applicant	Decline	Enroll- Requested Amount	Guaranteed Coverage Amount (only available during new hire enrollment. Requests above these amounts requires Life Insurance application)	Max Coverage- requires health statement to be completed
Employee	○	○ Number of $10,000 units _____	The lesser of 2 X's your salary or $200,000	The lesser of 5 X's your salary or $500,000
Spouse- up to age 70	○	○ Number of $10,000 units _____	$30,000	$50,000
Child(ren)- 14 days to age 23	○	○ Number of $2,000 units _____		$10,000

Beneficiary Designation

Basic Life Insurance – Policy No. FLX960295 (If needed, list additional beneficiaries on attached page)				
Employee's Primary Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100)
Employee's Contingent Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100)
Voluntary Term Life Insurance– Policy No. FLX960295 (If needed, list additional beneficiaries on attached page)				
Employee's Primary Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100)
Employee's Contingent Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100)

Guidelines for Designation of Beneficiaries

Primary and Contingent Beneficiaries- Unless you designate a percentage, proceeds are paid to the primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

General- Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Trust as Beneficiary- You may designate a trust as a beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under trust agreement dates [date of trust]." If you wish to designate a testamentary trust as a beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.

By completing this form you attest that your covered dependents are eligible dependents under the University of Richmond Employee Welfare Benefits Plan, or that you do not wish to cover dependents under the plan at this time. You understand that the University may require you to provide documentation to prove your dependents are indeed eligible for benefits, and you agree to provide such documentation upon request. You understand that your provision of dependent information is the basis on which dependent coverage will be provided under the plan. You acknowledge that you will notify the plan administrator of any changes to your dependent information within 31 days of the change. Any misstatement, omission or fraud by you may result in future claims being denied, your coverage and/or your dependents' coverage being prospectively terminated without notice and/or retroactively terminated upon 31 days' notice, and/or your submission to disciplinary action.

You, and any person authorized to act on your behalf, are entitled to receive a copy of this form upon the appropriate request.

_____ _____

Employee Signature **Date**