

## BENEFITS RESPONSE FORM

THIS FORM **MUST BE SIGNED & RETURNED** TO HUMAN RESOURCE SERVICES WITHIN 30 DAYS OF YOUR EMPLOYMENT DATE TO BE ELIGIBLE.

**Print Name:** \_\_\_\_\_ **ID #:** \_\_\_\_\_ **Employment Date:** \_\_\_\_\_

**Department:** \_\_\_\_\_ **Campus Phone:** \_\_\_\_\_  **Biweekly Paycheck**  **Monthly paycheck**

Group Health Insurance  
(PLEASE CHECK ONE)

- I am interested in participating in this plan. (submit application within 30 days of employment date)\*\*  
I understand that the University of Richmond will automatically deduct my health insurance premium from my paycheck on a pretax basis.
- I elect **not** to have this deduction taken before tax.
- I elect to waive the University's group medical insurance since I have other coverage. I have completed the Medical Waiver Form and attached a copy of my current coverage.

Dental Plan  
(PLEASE CHECK ONE)

- I am interested in participating in this plan. (submit application within 30 days of employment date)\*\*
- I am **not** interested in participating in this plan for the current calendar year.

Flexible Spending Accounts  
(PLEASE CHECK ONE)

- I am interested in participating in this program and I have completed the Flexible Spending Account application form. The total annual amount I wish to have deducted pre-tax for the remainder of this calendar year is listed below (an equal portion of this amount will be deducted from each of the remaining calendar year paychecks).
- |   |               |          |
|---|---------------|----------|
| <input type="checkbox"/> Medical Reimbursement        | Annual Amount | \$ _____ |
| <input type="checkbox"/> Dependent Care Reimbursement | Annual Amount | \$ _____ |
- I am **not** interested in participation in any one of these programs for the current calendar year.

Colonial Short Term Disability  
(PLEASE CHECK ONE)

- I am interested in applying for this coverage, you may call me at \_\_\_\_\_ to schedule an appointment.
- I am **not** interested in obtaining this coverage during this calendar year.

John Hancock Long Term Care Insurance  
(PLEASE CHECK ONE)

- Please send me information about long term care insurance to my department address
- I am **not** interested in obtaining this coverage during this calendar year

Voluntary Life Insurance  
(PLEASE CHECK ONE)

- I am interested in participating in this plan. (submit application within 30 days of employment date)\*\*
- I am **not** interested in participating in this plan for the current calendar year.

\*\* I understand that my decision will remain in effect and cannot be revoked or changed for the remainder of this plan year (January through December), unless a qualifying family status change occurs (e.g., marriage, divorce, death of a spouse or child, birth or adoption of a child, and termination of employment or change of employment for spouse) and the change is reported to Human Resource Services within 31 days.

(SIGNATURE)

(DATE)