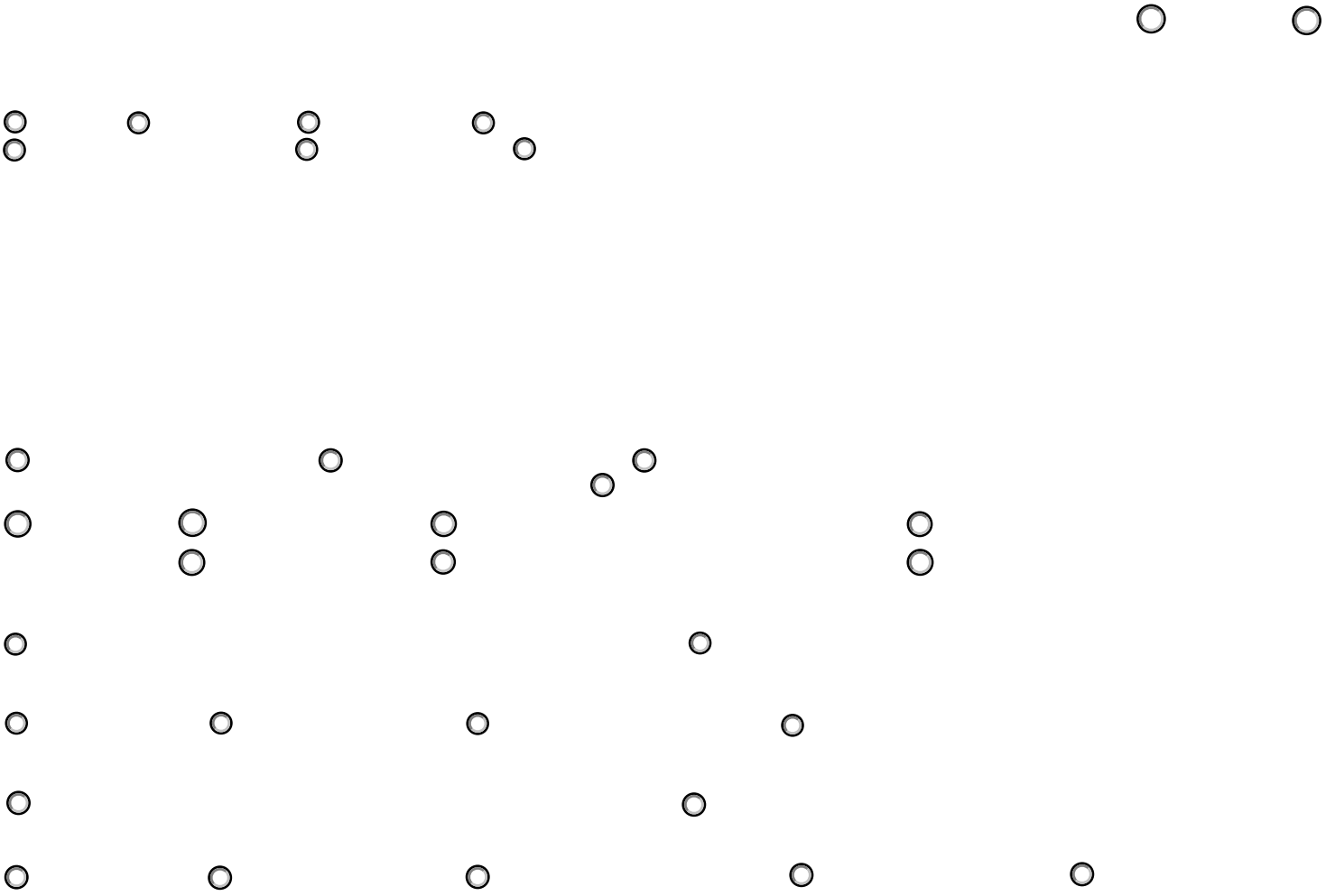

Select

Select

Select

Select

Select

Select

Select

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- ($2,700 household 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**

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

Affirmation of Spousal* Medical Insurance Coverage

Complete this form if you are enrolling your spouse in the University of Richmond's medical plan. If you are NOT enrolling your spouse in the University's medical plan this form is not needed. If your spouse is covered on the University's plan and you fail to complete this form or are late turning it in, you will be responsible for a surcharge in the amount of $100 per month. More information about the surcharge is on the back of this form.

Employee Name _____ **URID#** _____

Spouse Name _____

Form due date: Form is due 30 days from the qualifying event.

I am enrolling my spouse in the University of Richmond's health insurance plan:

☐My spouse is employed/retired, but is not eligible for or not offered health insurance through their employer or retirement plan.

Spouse's Employer or Retirement Plan Name and Human Resources Phone #:

_____

☐My spouse is unemployed or retired and not covered under any other employer-sponsored health coverage.

☐My spouse has coverage available through an employer or retirement plan, but I elect coverage on the University of Richmond's health insurance plan. I understand that I will be charged a $100 per month surcharge as a result.

CERTIFICATION

I do hereby attest that the above information is true and correct to the best of my knowledge. I acknowledge that falsification of any information may lead to disciplinary action, up to and including employment termination. I understand UR reserves the right to request supporting documentation and any proof as it, in its sole discretion, deems necessary in order to verify the representations I have made in this Affirmation. I also understand that if my spouse's group medical insurance status changes, it is my responsibility to notify Human Resources within 30 days of such change. I further understand a spouse surcharge may be terminated at the first of the month following timely notification to Human Resources. Spouse surcharge refunds for late notification are not permitted.

Employee Signature _____ **Date** _____

(Handwritten signature required)

Information about the Health Insurance Spousal Surcharge

UR imposes a **$100 per month surcharge** on employees that elect to cover spouses who are eligible for group medical coverage through their own employer, spouses that are retired and have access to a health plan through their previous employer or retirement plan, or spouses of participants on the COBRA plan. If, at any point, your spouse ceases to be eligible for their medical coverage, they may be enrolled in your UR medical plan. You will have 30 days from the loss of eligibility to enroll your spouse in UR's plan.

The surcharge will be treated as an additional premium and will be a pre-tax deduction. Monthly employees who are assessed the surcharge will have a $100 deduction each paycheck and hourly employees will have a $50 deduction each pay period (24 paychecks).

If your spouse's open enrollment occurred earlier in the year and your spouse chose not to enroll in coverage for which they were eligible for, they should contact their employer and request to enroll in their employer's benefit plan. An open enrollment under your spouse's employer's benefit plan is considered a mid-year change in status.

This surcharge does not apply toward dependent children. You are still able to enroll your dependent children in the UR medical plan regardless of your spouse's status under this restriction.

This surcharge does not apply to a spouse when both parties are employed at UR and covered under a UR plan.

Please complete this Affirmation and return it to Human Resources:

231 Richmond Way
Weinstein Hall, First Floor
University of Richmond, 23173
Fax: 804-287-1282
Email: URHR@richmond.edu

If you do not return this Affirmation and you are enrolling a spouse in a UR medical plan, you will be charged the $100 spousal surcharge until you submit this form. Spouse surcharge refunds for late notification are not permitted. You may not make any changes to your election until the following annual benefit enrollment period unless you experience a qualifying event.