University of Dayton Benefits Enrollment / Change Form Pre-Medicare Retirees

Name		UD ID #	
Address		Date of Birth	
City/State/Zip		Date of Hire	
Email Address		Social Security #	

Reason for Application   Effective Date: _____

□ Qualified Life Event □ Retirement □ Open Enrollment □ Add or Remove Dependent □ Waiver of coverage

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Qualified Life Event – Within 30 Days

□ Marriage / Divorce   □ Dependent loss/gain coverage   □ Dependent loss/gain employment

□ Over-age dependent   □ Other _____

Medical / Dental Waiver of Benefits

I fully understand the medical and dental plans that are offered by the University of Dayton. After careful consideration, I have decided to waive the benefit(s) indicated below. I understand that I **will not** be eligible to re-enroll unless within 30 days of a qualified life event (QLE). Proof of QLE will be required upon application.

□ Anthem Medical Plans   □ Superior Dental Plan

Signature: _____ Date: _____

Enrollment: Medical Insurance Options: Anthem	*HR Use Only*
□ Core Plan □ Advantage Plan □ Retiree Only □ Retiree + Spouse □ Retiree + Child(ren) □ Family	Effective Date: _____ Group-Sub-Group # _____
Enrollment: Dental Insurance Option: Superior Dental	*HR Use Only*
□ Superior Dental Plan (Preferred Plan) □ Single □ Family	Effective Date: _____ Group-Sub-Group # _____

List Spouse and Dependents Below

Relationship	Name	Social Security #	Date of Birth	Add / Remove	Plan
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental
				□ Add □ Remove	□ Medical □ Dental

If married, does (did) your spouse work for the University of Dayton in a benefit eligible position? □ *Yes* □ *No*

Spouse's Status: □ *Faculty* □ *Staff* □ *Grad Assistant*   *Spouse's Name:* _____

Terms, conditions, and authorizations:

I hereby authorize the University of Dayton to have Business Plans, Inc. invoice me for any applicable premiums for the elections made within this application. I understand that my elections made within this application must be provided to the Office of Human Resources within 30 days of a qualified life event. I authorize the University of Dayton to communicate to its vendors any information necessary to complete the enrollment / disenrollment process. I understand that the completion of this document is not a guarantee of coverage and that the Office of Human Resources and its vendors will make the determination on the acceptance of this request. I know that I am responsible for notifying Human Resources of any life event that might impact my benefit elections and changes needed.

This application hereby replaces any previous elections made and are fixed until:

1. My employment / benefit eligible status changes
2. I have a qualified life event and notify HR within 30 days
3. I fail to make premium payments for my coverage

I certify that this application is complete with accurate information and acknowledge that providing false information can lead to the denial of benefits.

Signature: _____   **Date:** _____

11/2018