**MEDICAL, DENTAL, & VISION INSURANCE**

**CAPITAL UNIVERSITY**
**Benefit Election/Changes Form**

| Employee Name: (Last Name, First, Middle Initial) | Social Security Number<br>_ _ _ - _ _ - _ _ _ _ | Date of Birth (MM/DD/YYYY)<br>_ _ / _ _ / _ _ _ _ |
|---|---|---|
| Street Address | Gender<br>☐ Male ☐ Female | Date of Hire (MM/DD/YYYY)<br>_ _ / _ _ / _ _ _ _ |
| City, State, Zip Code | Primary Telephone #<br>( ) | Work Telephone #<br>( ) |

## Qualifying Event

**Change:** ☐ New Enrollment/Additions ☐ Cancellation Effective Date: _____

**Reason for Application:** ☐ New Hire ☐ Change in FTE status ☐ Marriage ☐ Birth/Adoption ☐ Divorce ☐ Open Enrollment ☐ Death ☐ Spouse change in coverage ☐ Dependent no longer eligible ☐ Other: _____

## Medical Plan Election (Plan: 906439)

| | | | | |
|---|---|---|---|---|
| **Gold:** | ☐ Employee | ☐ Employee and Spouse | ☐ Employee and Child(ren) | ☐ Full Family |
| **Silver:** | ☐ Employee | ☐ Employee and Spouse | ☐ Employee and Child(ren) | ☐ Full Family |
| **Bronze:** | ☐ Employee | ☐ Employee and Spouse | ☐ Employee and Child(ren) | ☐ Full Family |

**Waiver of Participation:** *I choose to waive my rights to elect coverage for myself and my eligible dependents under Capital University's offered medical plan. I understand in the future I may be eligible to enroll in medical coverage during annual Open Enrollment, or if I have a qualifying event and Human Resources is in receipt of my completed enrollment form within 31 days of the change or eligibility.*

☐ I choose to waive participation in the medical plan

## Dental Plan Election (Plan: 5493)

☐ Employee ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Full Family

**Waiver of Participation:** *I choose to waive my rights to elect coverage for myself and my eligible dependents under Capital University's offered dental plan. I understand in the future I may be eligible to enroll in dental coverage during annual Open Enrollment, or if I have a qualifying event and Human Resources is in receipt of my completed enrollment form within 31 days of the change or eligibility.*

☐ I choose to waive participation in the dental plan

## Vision Plan Election (Plan: 35510)

☐ Employee ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Full Family

**Waiver of Participation:** *I choose to waive my rights to elect coverage for myself and my eligible dependents under Capital University's offered vision plan. I understand in the future I may be eligible to enroll in vision coverage during annual Open Enrollment, or if I have a qualifying event and Human Resources is in receipt of my completed enrollment form within 31 days of the change or eligibility.*

☐ I choose to waive participation in the vision plan

## Dependent Information

I wish to cover the following dependents under my medical and/or dental plan as indicated below:

| Relation | Medical | Dental | Vision | Name (Last, First, MI) | Gender | Birthdate | Social Security # |
|---|---|---|---|---|---|---|---|
| **Spouse** | ☐ | ☐ | ☐ | | | | |
| **Child** | ☐ | ☐ | ☐ | | | | |
| **Child** | ☐ | ☐ | ☐ | | | | |
| **Child** | ☐ | ☐ | ☐ | | | | |
| **Child** | ☐ | ☐ | ☐ | | | | |

## Signature

I acknowledge that I have received the "Important Information" statement which is included below. I confirm that the information I have provided on this form is complete and accurate. I authorize Capital University to deduct from my earnings the amount required for my share of the premiums for these benefits. If I elect to participate in pretax benefits, I authorize Capital University to reduce my taxable income by the amount equal to my share of these premiums.

**Signature:** _____ **Date:** _____

## Important Information

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Medical Plan Information:** Coverage is being provided by UnitedHealthcare. The plan documents (Schedule of Benefits, Group Agreement, Group Policy and Certificate of Coverage) will determine my rights and responsibilities and will govern even if they conflict with any benefits comparisons, summary or other description of the plan.

**Dental Plan Information:** Coverage is being provided by Delta Dental Plan of Ohio. The plan documents (Schedule of Benefits, Group Agreement, Group Policy and Certificate of Coverage) will determine your rights and responsibilities and will govern even if they conflict with any benefits comparisons, summary or other description of the plan.

**Vision Plan Information:** Coverage is being provided by Superior Vision. The plan documents (Schedule of Benefits, Group Agreement, Group Policy and Certificate of Coverage) will determine your rights and responsibilities and will govern even if they conflict with any benefits comparisons, summary or other description of the plan.

| | | |
|---|---|---|
| **FOR OFFICE USE ONLY:** | Date Medical entered into carrier website: _____ | Date Dental entered into carrier website: _____ |
| | Date Medical entered into Colleague: _____ | Date Dental entered into Colleague: _____ |

*Revised: 10/2016*