



New Enrollment (Waiting periods apply. Please refer to *Benefits Handbook*.)
 Late Enrollment (Please refer to *Benefits Handbook* for rules on late enrollment.)
 Open Enrollment
 Change: Coverage (Complete Parts A,B,C,D,F,G,H,I) Name (Complete Parts A,I)
 Health Plan (Complete Parts A,B,D,H,I) Life Insurance Beneficiary (Complete Parts A,E,F,I)

Benefits Enrollment Form

PART A Legal Marital Status: Married Not Married Sex: Male Female Date of Birth: _____ Employment Date: _____

Name: LAST FIRST MI FORMER LAST NAME (IF CHANGED) SOCIAL SECURITY NUMBER

Address: STREET OR P. O. BOX CITY STATE ZIP CODE TELEPHONE E-MAIL ADDRESS

PART B MEDICAL INSURANCE COVERAGE RF PPO Plan HMO Name (Additional form required): _____ I Decline Coverage

Please choose one of the following:
 Employee Only Employee & Child(ren) Employee & Family
 Employee & Spouse or Domestic Partner (requires additional documentation and approval)

Immediate prior coverage with Blue Cross? Yes No Do you or any of your dependents have any other group health insurance? Yes No
 If yes, please indicate policyholder, insurance company, and identification number: _____

PART C DENTAL COVERAGE Employee Only Family I Decline Coverage **VISION COVERAGE** Employee Only Family I Decline Coverage

PART D DEPENDENTS – COMPLETE IN FULL – LIST ANY ADDITIONAL DEPENDENTS ON BACK OF THIS FORM

ADD	DELETE	LAST NAME	FIRST NAME	MI	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	TYPE OF COVERAGE
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

PART E BENEFICIARY DESIGNATION-BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE*

NAME	PERCENT	RELATIONSHIP	DATE OF BIRTH	ADDRESS	BENEFICIARY DESIGNATION	
					Primary-Class 1	Contingent-Class 2
					<input type="checkbox"/> Primary	<input type="checkbox"/> Contingent
					<input type="checkbox"/> Primary	<input type="checkbox"/> Contingent
					<input type="checkbox"/> Primary	<input type="checkbox"/> Contingent

***IMPORTANT:** Please list your beneficiaries for your Basic Life and AD&D insurance. List additional beneficiaries on back of this form. Benefit is payable to contingent beneficiary ONLY if all primary beneficiaries are deceased. (If a class of beneficiaries contains more than one person, the benefit is apportioned equally unless specified otherwise.)

PART F OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE I Elect Coverage I Decline Coverage

Employee Paid – Submit within 60 days of hire or medical statement required Multiple of earnings, offset by Basic Life amount 1X 2X 3X 4X 5X 6X 7X

List additional beneficiaries on back of this form. Beneficiaries will be the same as for Basic Life (Part E), unless you list different beneficiaries on the back of this form.

PART G DEPENDENT OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE I Elect Coverage (Additional form required) I Decline Coverage **OPTIONAL SUPPLEMENTAL SHORT-TERM DISABILITY INSURANCE** I Elect Coverage (Additional form required) I Decline Coverage

PART H MEDICAL INSURANCE PLAN CHANGE Date of change: _____ **DEPENDENT COVERAGE CHANGES** Date of change: _____

Open Enrollment **From:** RF PPO Plan **To:** RF PPO Plan
 Moving out of area HMO Plan _____ HMO Plan _____
 Decline Coverage Decline Coverage
 Other _____ Other _____

Reason for change:
 Marriage Newly eligible for coverage Dependent died
 Spouse's coverage terminated Child reached age limit Divorce
 Other, specify _____ No longer a student Birth/Adoption

PART I I hereby authorize deductions from my salary of the amount required, if any, for the insurance indicated. This authorization will be in effect until revoked in writing. Medical and dental insurance deduction is paid on a pre-tax basis unless a waiver form is submitted. (See *Benefits Handbook* for pre-tax medical insurance deduction information.)

EMPLOYEE SIGNATURE _____ DATE _____

Health Effective Date	Dental Effective Date	Vision Effective Date	Basic Life/AD&D Effective Date	Optional Life/AD&D Effective Date	NYS DBL Effective Date	LTD Effective Date	Campus Location
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