THE UNIVERSITY of NEW ORLEANS

VOLUNTARY BENEFITS ENROLLMENT/CHANGE FORM

Check the box for the Plan you would like to enroll in or make changes to. All Employee and applicable Dependent sections must be completely filled out in the event you are making changes. Descriptions of each Plan can be found on the employee benefits website. Contact your HRM Benefits Staff for additional information.
Note: All premiums on this form are MONTHLY (12 months).

FOR OFFICE USE ONLY (All fields are REQUIRED)

Effective Date of Change: ______________________
HR/Payroll Rep: ______________________
Pay Type: ______________________
Date Event Occurred: ______________________

TYPE OF CHANGE (REQUIRED)

☐ Birth/Adoption	☐ New Hire	☐ Death
☐ Marriage	☐ Emp Status	☐ Divorce
☐ Retirement	☐ Termination	☐ Add/Delete Dependent
☐ Cancellation	☐ Demographic Change	☐ Other ______________
☐ Annual Enrollment		

Last Name	First Name	MI	Date of Birth	Social Security #	Date of Hire
Mailing Address			City	State	Zip Code

Gender	Home Telephone #	Work Telephone #	Email Address	Marital Status	Marital Date

☐ Add ☐ Delete	**SPOUSE**	Last Name	First Name	MI	Social Security #	Gender	DOB
☐ Add ☐ Delete	**DEPENDENT**	Last Name	First Name	MI	Social Security #	Gender	DOB
☐ Add ☐ Delete	**DEPENDENT**	Last Name	First Name	MI	Social Security #	Gender	DOB
☐ Add ☐ Delete	**DEPENDENT**	Last Name	First Name	MI	Social Security #	Gender	DOB
☐ Add ☐ Delete	**DEPENDENT**	Last Name	First Name	MI	Social Security #	Gender	DOB
Address if different from employee		Mailing Address			City	State	Zip Code

VISION

I would like to enroll in the following plan and level of coverage:

	Employee Only	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
Designer Plan	☐ $8.80	☐ $15.86	☐ $16.74	☐ $26.42
Premier Plan	☐ $9.80	☐ $17.66	☐ $18.64	☐ $29.44

☐ I would like to cancel my vision coverage. ☐ I do not wish to enroll. ☐ Currently Enrolled

DENTAL

	Employee Only	**Employee & Spouse**	**Employee & Child(ren)**	**Family**
Basic Plan	☐ $22.12	☐ $41.54	☐ $57.40	☐ $76.80
Enhanced Plan	☐ $47.20	☐ $92.28	☐ $112.20	☐ $157.30

☐ I would like to cancel my dental coverage. ☐ I do not wish to enroll. ☐ Currently Enrolled

LONG TERM DISABILITY

☐ Yes, I would like to enroll in Long Term Disability

$ ________________ Monthly Salary x $0.00553 = $ ____________ Premium

☐ I would like to cancel my Long Term Disability Coverage.
☐ I do not wish to enroll.
☐ Currently Enrolled

ACCIDENTAL DEATH & DISMEMBERMENT

I would like to enroll in the AD&D plan with the following level of coverage:

- ☐ Principal Sum $27,500
  - ☐ Employee Only $1.00
  - ☐ Family $1.50
- ☐ Principal Sum $55,000
  - ☐ Employee Only $2.00
  - ☐ Family $3.00
- ☐ Principal Sum $82,500
  - ☐ Employee Only $3.00
  - ☐ Family $4.50
- ☐ Principal Sum $110,000
  - ☐ Employee Only $4.00
  - ☐ Family $6.00
- ☐ Principal Sum $165,000
  - ☐ Employee Only $6.00
  - ☐ Family $9.00
- ☐ Principal Sum $220,000
  - ☐ Employee Only $8.00
  - ☐ Family $12.00
- ☐ Principal Sum $275,000
  - ☐ Employee Only $10.00
  - ☐ Family $15.00
- ☐ Principal Sum $300,000
  - ☐ Employee Only $10.90
  - ☐ Family $16.36

- ☐ I would like to cancel my AD&D
- ☐ I do not wish to enroll
- ☐ Currently Enrolled

AD&D Beneficiary Designation

Primary Name(s)	Relationship	% of Benefit
1.		
2.		
3.		
4.		
Contingent Name(s)	**Relationship**	**% of Benefit**
1.		
2.		
3.		
4.		

IMPORTANT DETAILS:

I have been given the opportunity to enroll in the University of New Orleans' Group Accidental Death & Dismemberment and Long Term Disability Insurance plan(s). **I understand that if I decline to enroll in the Long Term Disability plan now, but later decide to enroll, I will be required to provide evidence of good health and understand my request for coverage may be denied.** I also understand that the evidence of good health requirement for the Long Term Disability plan will need to be met when changes in family status occur.

In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual.

If I have Long Term Disability coverage, I understand and agree that the maximum duration benefits payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition and be subject to certain offsets.

I authorize my employer to deduct from my wages the premiums, if any, for the elected coverage. To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that any persons who knowingly present a false or fraudulent claim for payment of loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. I am also confirming that I have read and understand the Important Details outlined on this document.

Employee Signature: ____ Date: ___________________________