Benefits Enrollment Form

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

PART B
MEDICAL INSURANCE COVERAGE  ☐ Traditional PPO  ☐ Deductible PPO  ☐ 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)

PART C
DENTAL COVERAGE  ☐ Employee Only  ☐ Family  ☐ I Decline Coverage  VISION PLAN  ☐ Regular  ☐ Plus  ☐ I Decline

Choose One: ☐ Employee Only  ☐ Family

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

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

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  ☐ 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

PART H
MEDICAL INSURANCE PLAN CHANGE  Date of change:  

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, dental, and vision 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