

# ROCHESTER INSTITUTE OF TECHNOLOGY

## Benefits Enrollment/Change Form

Name: \_\_\_\_\_

Employee #: \_\_\_\_\_

Department: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

Employment Category:  Full-Time  Ext. Part-Time

Pay Type:  Non-Exempt  Exempt

### REASON FOR COMPLETING THIS FORM

**New Employee** – most benefits will begin the first of the month on or after date of hire, unless noted. *Complete all sections of this form and sign and date the form on the last page.*

**Mid Year Change (check one box below)** – changes made during the year must be due to qualified changes in family or employment status, must be made within 31 days of the event, and must be consistent with the event. Complete **only those sections** of this form that you are **changing** and **sign and date the form** on the last page.

Event Date: \_\_\_\_\_ (effective date for the event checked below)

- Marriage/Domestic Partnered  Divorce  Birth/Adoption of Child  Death of Spouse/Dependent  
 Employee ExPT or PT to FT Status  Employee FT to ExPT or PT Status  Employee Return from leave  
 Child became FT Student  Child age 19-23, no longer FT Student  Child reached age limit of Plan  
 Spouse/Domestic Partner gains employment  Spouse/Domestic Partner loses employment  
 Other \_\_\_\_\_

### BEFORE-TAX ELECTIONS

#### MEDICAL INSURANCE (you must also complete a separate insurance form if enrolling, cancelling, or changing)

I ELECT TO  enroll  decline/waive  change  cancel

- Individual  2 Person  
 Family  One Parent Family

(If covering domestic partner, complete additional forms)

- Blue Point2 POS A  Blue PPO (those living  
 Blue Point2 POS B outside POS service area)  
 Blue Point2 POS B No Drug

#### DENTAL INSURANCE (you must also complete a separate insurance form if enrolling, cancelling, or changing)

I ELECT TO  enroll  decline/waive  change  cancel

- Individual  2 Person  Family (If covering domestic partner, complete additional forms)

#### VISION CARE PLAN (you must also complete a separate form if enrolling, cancelling, or changing)

I ELECT TO  enroll  decline/waive  change  cancel

- Individual  2 Person  Family (If covering domestic partner, complete additional forms)

#### BENEFLEX

I ELECT TO  enroll  decline/waive  change  cancel

##### Dependent Care Spending Account (DCSA)

I elect to participate in the DCSA as follows:

- Total Contribution\* \_\_\_\_\_  
(maximum \$5,000\*\*)

\* from your date of participation through December 31  
\*\* IRS calendar year limit per family from all employers

##### Health Care Spending Account (HCSA)

I elect to participate in the HCSA as follows:

- Total Contribution\* \_\_\_\_\_  
(maximum \$3,000)

\* from your date of participation through December 31

**AFTER-TAX ELECTIONS**

**SUPPLEMENTAL AND DEPENDENT LIFE INSURANCE**

**Supplemental:** I ELECT TO  enroll  decline/waive  change  cancel  
 1 x base pay  2 x base pay  3 x base pay  4 x base pay  5 x base pay

If elected, have you used tobacco products at any time in the last 12 months?  No  Yes

(NOTE: insurance company approval may be required)

**Spouse:** I ELECT TO  enroll  decline/waive  N/A-No Spouse  change  cancel  
 \$25,000  1 x base pay  2 x base pay  3 x base pay  4 x base pay  5 x base pay

If elected, has your spouse used tobacco products at any time in the last 12 months?  No  Yes

**Child(ren):** I ELECT TO  enroll  decline/waive  N/A-No Child  change  cancel  
 \$5,000  \$10,000

(NOTE: insurance company approval may be required)

**SUPPLEMENTAL AND DEPENDENT ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE**

**Supplemental:** I ELECT TO  enroll  decline/waive  change  cancel  
 1 x base pay  2 x base pay  3 x base pay  4 x base pay  5 x base pay

**Spouse:** I ELECT TO  enroll  decline/waive  N/A-No Spouse  change  cancel  
 \$25,000  1 x base pay  2 x base pay  3 x base pay  4 x base pay  5 x base pay

**Child(ren):** I ELECT TO  enroll  decline/waive  N/A-No Child  change  cancel  
 \$5,000  \$10,000

**SUPPLEMENTAL LONG-TERM DISABILITY**

I ELECT TO  enroll  decline/waive  cancel

**GROUP LEGAL SERVICES PLAN (HYATT LEGAL)**

I ELECT TO  enroll  decline/waive  cancel

**EMPLOYEE SIGNATURE**

I authorize RIT to reduce my salary by the applicable before-tax dollars or deduct from my paycheck the applicable after-tax dollars for the insurance programs I elected above. Unless stated otherwise, I understand that I cannot change my elections until the annual Open Enrollment, unless I have a change in family or employment status. **If I have a change in family or employment status, I understand that I must elect this change in writing within 31 days of the event change date and that the change elected is consistent with the event.** Should there be an increase in any insurance premiums during a Plan Year, the University may adjust my reductions/deductions. If I am required to complete an Evidence of Insurability form, I understand the coverage change will not take effect until the insurance company approves the election. I further understand that RIT reserves the right to change, modify, audit, discontinue or terminate benefits at any time for any reason and that the insurance companies may from time to time change their policies. I understand that if I do not elect an option, my coverage will default to decline/waive coverage and I will not be able to make a mid-year change other than for a change in family or employment status as explained above. I affirm that any family member(s) I elect to cover is eligible and that I am required to submit copies of proof of eligibility. I understand that if I submit this form for a family member who is not eligible that I will be in violation of RIT Policy which may result in ineligibility for the benefit and/or discipline up to and including termination of employment.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_