ROCHESTER INSTITUTE OF TECHNOLOGY
Benefits Enrollment/Change Form
Adjunct Employees

Name: _____ **Employee #.:** _____

Department: _____ **Daytime Phone:** _____

Date of Birth: _____ **Date of Hire:** _____

Employment Category: ❑ Adjunct **Pay Type:** ❑ Non-Exempt ❑ Exempt

REASON FOR COMPLETING THIS FORM

❑ **Open Enrollment**

❑ **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/Domestic Partner/Child
❑ Employee Employment Category Change (e.g., PT to FT)
❑ Spouse/DP gains employment ❑ Spouse/DP loses employment
❑ Other _____

BEFORE-TAX ELECTIONS

MEDICAL COVERAGE

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 Point2 POS D ❑ Blue Point2 POS B ❑ Blue PPO *(those living)* ❑ Blue Point2 POS B No Drug *outside POS service area)*

DENTAL COVERAGE

I ELECT TO ❑ enroll ❑ decline/waive ❑ change ❑ cancel

NOTE: this election is effective for 2017 and 2018

❑ Individual ❑ 2 Person ❑ Family *(If covering domestic partner, complete additional forms)*	❑ Dental Plan-Standard ❑ Dental Plan Enhanced

VISION CARE COVERAGE

I ELECT TO ❑ enroll ❑ decline/waive ❑ change ❑ cancel

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

HEALTH CARE ENROLLMENT INFORMATION

Only complete the Employee Information section if you are enrolling for coverage for the first time.

Employee Information

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phones: Work: _____ **Home:** _____ **Cell:** _____

Gender: ❑ Female ❑ Male **Email:** _____

Eligible for Medicare: ❑ No ❑ Yes *(due to disability or at least age 65)*

Marital Status: ❑ Single ❑ Married/Domestic Partnered ❑ Legally Separated ❑ Divorced

Primary Care Physician *(if enrolling in medical)*

Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

Ob/Gyn *(if enrolling in medical)*

Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

Prior Coverage Information: Have you ever been a member of Excellus BlueCross BlueShield? ❑ Yes ❑ No

Have you, your spouse/domestic partner or any enrolled dependent had other coverage within the last 63 days?
Medical? ❑ Yes ❑ No If yes, are you keeping the additional coverage? ❑ Yes ❑ No

Dental? ❑ Yes ❑ No If yes, are you keeping the additional coverage? ❑ Yes ❑ No

Who did the other plan cover? ❑ Self ❑ Spouse/Domestic Partner ❑ Children

Other Insurance Carrier Name: _____

Name of Policy Holder: _____ Policy ID Number: _____

Coverage Effective Date: _____ Coverage Termination Date: _____

Family Member Information

*If enrolling or adding family members, list all requested information. Social Security Number **required** for Federal reporting if enrolling in Medical. If cancelling a family member, list only the name of the person you are cancelling.*

First Name: _____ **Last Name:** _____

Enroll In: ❑ Medical ❑ Dental ❑ Vision **Social Security Number:** _____ (***required*** **for Federal reporting)**

Gender: ❑ Female ❑ Male

Date of Birth: _____ **Eligible for Medicare:** ❑ No ❑ Yes *(due to disability or at least age 65)*

Relationship: ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Step-Child ❑ Domestic Partner's Child

Primary Care Physician *(if enrolling medical)*

Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

Ob/Gyn *(if enrolling in medical)*

Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

HR Use: Proof ❑ Marriage Cert. ❑ Marriage-Tax Return ❑ Birth Cert. ❑ Other _____ Date: _____

First Name: _____ **Last Name:** _____

Enroll In: ❑ Medical ❑ Dental ❑ Vision **Social Security Number:** _____ (***required*** **for Federal reporting)**

Gender: ❑ Female ❑ Male

Date of Birth: _____ **Eligible for Medicare:** ❑ No ❑ Yes *(due to disability or at least age 65)*

Relationship: ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Step-Child ❑ Domestic Partner's Child

Primary Care Physician *(if enrolling medical)*

Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

Ob/Gyn *(if enrolling in medical)*

Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

HR Use: Proof ❑ Marriage Cert. ❑ Marriage-Tax Return ❑ Birth Cert. ❑ Other _____ Date: _____

First Name: _____ **Last Name:** _____

Enroll In: ❑ Medical ❑ Dental ❑ Vision **Social Security Number:** _____ (***required*** **for Federal reporting)**

Gender: ❑ Female ❑ Male

Date of Birth: _____ **Eligible for Medicare:** ❑ No ❑ Yes *(due to disability or at least age 65)*

Relationship: ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Step-Child ❑ Domestic Partner's Child

Primary Care Physician *(if enrolling medical)*

Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

Ob/Gyn *(if enrolling in medical)*

Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

HR Use: Proof ❑ Marriage Cert. ❑ Marriage-Tax Return ❑ Birth Cert. ❑ Other _____ Date: _____

First Name: _____ **Last Name:** _____

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Last Name: _____

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Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

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Last Name: _____

First Name: _____

Current Patient? ❑ Yes ❑ No

HR Use: Proof ❑ Marriage Cert. ❑ Marriage-Tax Return ❑ Birth Cert. ❑ Other _____ Date: _____

EMPLOYEE SIGNATURE

I authorize RIT to reduce my salary by the applicable before-tax dollars. If my paycheck is too small to take deductions, I understand that I will be billed for my coverage. 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, with the exception of dental coverage, which has a two-year lock in with limited changes allowed. **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 premium contributions during a Plan Year, the University may adjust my reductions/deductions. 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 before they can be covered. 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.

Excellus BCBS Release: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the state value of the claim for each such violation. By signing below, I grant permission to Excellus BCBS to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer. I authorize Excellus BCBS to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefits managers, disease management vendors or surveyors. If enrolling in the Blue PPO, I understand that the PPO coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

_____ _____

Employee Signature Date