UNIVERSITY OF HARTFORD

2017 OPEN ENROLLMENT REQUEST FORM
REGULAR PART-TIME EMPLOYEES (30 or more hours per week)

Name
Department

YOU ARE CURRENTLY ENROLLED IN THE FOLLOWING BENEFITS:

Please select your calendar year (CY) 2017 benefit elections below. Open Enrollment Request Forms must be returned to the Office of Human Resources Development (HRD) by 4:30pm on Friday, November 18, 2016. All elections become effective January 1, 2017.

MEDICAL INSURANCE – United HealthCare

Note: Enrollment, changes or termination of coverage requires completion of an enrollment change form.

STEP 1 – Confirm your plan election: ☐ Deductible-based Plan (DBP) ☐ Point of Service (POS) Plan ☐ I do not wish to purchase

Select Medical Insurance Premium Payment Method (if enrolling): ☐ Pre-tax bi-weekly payroll deduction ☐ Post-tax monthly direct billing

STEP 2 – Confirm who will be covered under your medical insurance plan:

☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Employee + spouse + child(ren)

Consider "rallying" towards better health by participating in the University's online voluntary wellness program! Rally is an enhanced and integrated digital health and wellness experience that gives members access to tools, information and communities which help maintain and/or improve general health and wellbeing. Beginning January 1, 2017, log into www.myuhc.com and experience Rally for yourself!

PRE-TAX SAVINGS ACCOUNT – for covered health care services and qualified medical expenses

*Note: Participation in a pre-tax savings account does not automatically default; therefore, you must submit a Participation and Salary Reduction Agreement Form for enrollment in an FSA or HSA for CY 2017.

Health Savings Account * (partners only with the DBP)

☐ Individual ($3,400 annual maximum, including a $750 pro-rated University contribution)
☐ Family ($6,750 annual maximum, including a $1,500 pro-rated University contribution)

Note: If you are over age 55, the catch-up provision allows you to contribute an additional $1,000.

Health Reimbursement Account (partners with the DBP for employees deemed Medicare eligible)

☐ Individual ($750 pro-rated University Contribution) ☐ Family ($1,500 pro-rated University Contribution)

Flexible Spending Account (FSA) *

☐ Health Care FSA ($2,550 annual maximum) ☐ Dependent Care FSA ($5,000 annual maximum)

DENTAL INSURANCE – Aetna Freedom of Choice

Note: Enrollment, changes or termination of coverage requires completion of an enrollment change form.

☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Employee + spouse + child(ren) ☐ I do not wish to purchase

Select Dental Insurance Premium Payment Method (if enrolling): ☐ Pre-tax bi-weekly payroll deduction ☐ Post-tax monthly direct billing

VISION INSURANCE – United HealthCare

Note: Enrollment, changes or termination of coverage requires completion of an enrollment change form.

☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Employee + spouse + child(ren) ☐ I do not wish to purchase

Select Vision Plan Premium Payment Method (if enrolling): ☐ Pre-tax bi-weekly payroll deduction ☐ Post-tax monthly direct billing

LIFE INSURANCE – Aetna

Note: Enrollment, changes or termination of coverage requires completion of an enrollment change form.

Optional Life Insurance(s) – Please check one box in each category below.

	Continue Current Election	Make Changes (enroll, increase, decrease or drop coverage)	I Do Not Wish to Enroll
Supplemental Life Insurance	☐	☐	☐
Spousal Life Insurance	☐	☐	☐
Dependent Child(ren) Life Insurance	☐	☐	☐
Personal Accident Insurance	☐	☐	☐

Select Optional Life Insurance Premium Payment Method (if enrolling): ☐ Pre-tax bi-weekly payroll deduction ☐ Post-tax monthly direct billing

ACKNOWLEDGMENT, AUTHORIZATION AND RELEASE

I understand that if HRD does not receive all completed open enrollment materials required during open enrollment, current CY 2016 medical, dental and/or optional life insurance elections will automatically be defaulted for CY 2017 and cannot be revoked or changed during the plan year unless I have a qualifying event as defined by IRS regulations (such as marriage, divorce, birth or adoption of child, or termination of coverage under a spouse's plan).

I authorize the University of Hartford to enroll me in the benefits I have elected herein and to collect the associated premium based on the payment method I have selected. I agree to make the necessary premium payments for all elected coverage(s) for as long as I am enrolled in the plan(s). I understand that I can remit insurance premium(s) on a pre-tax or a post-tax basis. If I elect the post-tax monthly billing payment method and fail to remit timely premium payments for selected benefits, I understand that any and all benefit elections with an outstanding balance greater than 60 days will be cancelled retroactively to the last paid-through date. I further understand that any deductions for flexible spending or health savings accounts will be deducted from my pay on a pre-tax basis.

My signature below indicates that I have read and understand this election form and the descriptive material available. The election(s) I have selected herein are binding for one year and cannot be revoked or modified except under limited circumstances (qualifying events) as defined by IRS regulations. I declare that the dependents enrolled in the benefits noted herein are my eligible dependents. I declare that the information furnished on this form is true, correct and complete to the best of my knowledge.

_____	(860)_____	_____@hartford.edu	_____
Signature	**Work Phone**	**Email**	**Date**

HRD USE ONLY: [ ] PDADEDN [ ] PDABCOV Initials: _____ Date: _____ Audit Completed: Initials: _____ Date: _____