University of Missouri – 2014 Annual Enrollment Form

Employee Last Name	Employee First Name	MI	Employee ID (not SSN)	Social Security Number

Street	Hire Date	Date of Birth

City	State	Zip	Home Phone	Work Phone	Gender

- This form is to be used for Annual Enrollment Changes. Changes will be effective January 1, 2014.
- This form must be completed and returned by November 1, 2013.
- Changes may be made online using self-service through myHR www.myhr.umsystem.edu
- Make your benefit selections (section I)
  - Your contributions for the medical, dental, vision, life insurance (2 x salary), and the long-term disability (Option B) are deducted on a before-tax basis, unless you are exempt from federal or state taxes or specifically elect otherwise.
  - If you want to change how you pay your share of the benefit costs from an after-tax to a before-tax basis, or vice versa, you can only do so during the annual enrollment change period.
- Complete the *Dependent Information* (section II) and provide the required proof of relationship within 30 days from date of coverage if you are adding new dependents.
- Complete the *University Beneficiary Designation* form for your Basic Life Plan, Accidental Death & Dismemberment, and/or Pre-Retirement Death Benefits.
- Read, sign and date the *Authorization and Acknowledgements* (section III). Return both forms to your Campus Benefit Representative (CBR). **Please be sure to make a copy for yourself.**

I. ENROLLMENT OPTIONS:

Pre-tax unless this box is checked for an after tax contribution ☐

Medical	Employee Only	Employee + Spouse	Employee + Child/ren	Employee + Family
myChoice Health Plan	☐ (13) $138.50	☐ (14) $305.98	☐ (15) $235.62	☐ (16) $401.34
myOptions Health Plan**	☐ (01) $84.96	☐ (02) $187.70	☐ (03) $144.60	☐ (04) $246.28
Decline	☐ (W) waive - Please indicate reason for waive below			
	☐ other coverage	☐ unaffordable	☐ religious reasons	☐ not interested

** If you enroll in the myOptions Health Plan, you will also need to complete the HSA Enrollment Form

Pre-tax unless this box is checked for an after tax contribution ☐

Dental	Employee Only	Employee + Spouse	Employee + Child/ren	Employee + Family
Dental Plan	☐ (01) $14.76	☐ (02) $29.52	☐ (03) $35.82	☐ (04) $50.58
Decline	☐ (W) waive			

Pre-tax unless this box is checked for an after tax contribution ☐

Vision	Employee Only	Employee + Spouse	Employee + Child/ren	Employee + Family
Vision Plan	☐ (01) $5.62	☐ (02) $11.22	☐ (03) $12.24	☐ (04) $19.38
Decline	☐ (W) waive			

Option B is pre-tax unless this box is checked for an after tax contribution ☐

Basic Life	Option A (1 x base salary & age graded)*	Option B (2 x base salary & age graded)*
Basic Life Insurance	☐ (01) $0.00	☐ (02) $.03 per $1000 of coverage
Decline	☐ (W) waive	

After Tax Contribution

AD&D	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000
AD&D - Self	☐ (01) $.53	☐ (02) $1.05	☐ (03) $1.58	☐ (04) $2.10	☐ (05) $2.63	☐ (06) $3.15
AD&D – Family	☐ (07) $.73	☐ (08) $1.45	☐ (09) $2.18	☐ (10) $2.90	☐ (11) $3.63	☐ (12) $4.35
Decline	☐ (W) waive					

After Tax Contribution (rates will vary based on age)

Supplemental Life*	Supplemental life options are 1, 2 or 3 times your annual base salary. You may elect or increase your supplemental life coverage. Please request the applicable form from your Campus Benefit Representative.

After Tax Contribution (rates will vary based on age)

Spouse Life	$10,000*	$20,000*	$30,000*	$40,000*	$50,000*
Spouse	☐ (01)	☐ (02)	☐ (03)	☐ (04)	☐ (05)
Decline	☐ (W) waive				

After Tax Contribution

Dependent Life Child/ren	$5,000*	$10,000*	$15,000*	$20,000*	$25,000*
Dependent Child/ren	☐ (01) $0.35	☐ (02) $0.70	☐ (03) $1.05	☐ (04) $1.40	☐ (05) $1.75
Decline	☐ (W) waive				

SEE BACK

Option B is pre-tax unless this box is checked for an after tax contribution ☐

Long Term Disability	Option A*	Option B*
Long Term Disability	☐ (01) $0.00	☐ (02) $.21 per $100 of monthly income
Decline	☐ (W) waive	

*Evidence of insurability is required. Applicable forms may be obtained from your Campus Benefit Representative.

III. DEPENDENT INFORMATION:

In the table below list your current dependents and their respective information.

- If you wish to add new dependents to the list, please add their name to the list and provide the indicated information.
  - Under the medical, dental, and vision column, please enter 'yes' if you want coverage or 'no' if you do not want coverage.
  - Proof of relationship is required for new dependents enrolled under Medical, Dental and/or Vision..
- If you wish to make a change to an existing dependent's coverage medical, dental or vision coverage, please write in either 'yes' or 'no' as applicable.
- If you wish to delete a dependent for all coverage including spouse or dependent life insurance, please cross out the name.
- If you wish to keep a dependent listed for only spouse or dependent life insurance, leave the name on the list and enter a 'no'

Dependent/Spouse/Sponsored Adult Dependent Name	**Relationship**	**Gender**	**Date of Birth**	**Social Security Number**	**Coverage**		
					Medical	Dental	Vision

V. AUTHORIZATION AND ACKNOWLEDGEMENTS:

Election Authorization

I hereby make the above elections and I authorize the University of Missouri to deduct/redirect the appropriate amounts from my pay for the coverages elected. (I also hereby authorize the appropriate providers to release any documentation necessary to pay my or my dependents´ claims.)

I understand it is my responsibility to inform the University Benefits office of desired changes in coverage and/or changes in my family status or personal information that affect my benefit coverage or eligibility by completing an Enrollment Change form within 31 days of the event.

Acknowledgements:

I acknowledge that in the event that I or any of my dependents become ineligible for coverage under the Plan, applicable contribution refunds will be made, provided the Plan receives notification of an enrollment change within 31 days of a Qualifying Event which results in a reduction of contributions. If I fail to provide notice of an enrollment change within 31 days of a Qualifying Event which would result in a reduction of contributions, a refund of the contributions overcharge, not to exceed the first two ineligible months' contributions rates, will be made to me. Any claims paid on behalf of an ineligible individual must be reimbursed to the Plan by me before a contribution refund will be made.

_____ _____ _____

Employee ID or SSN | Signature of Employee | Date