



**2009 Benefits Enrollment Form  
For Faculty and Staff Employee**

<b>DENTAL</b>
Please select one option below. You may elect dental coverage even if you do not have medical coverage. If you do not make an election, you will not have dental coverage.
<b>Aetna High Option</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Employee + Family
<b>Aetna Low Option</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Employee + Family
<b>Aetna DMO</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Employee + Family
<b>Waive Coverage</b> <input type="checkbox"/>

<b>DEPENDENTS</b>								
You may cover your spouse or domestic partner and/or dependent children under the medical and dental plans. Please complete the information below for each individual you wish to cover (or delete from coverage). Be sure to check one or both plans, as applicable.								
Option	SSN	Name	Sex	DOB	Relationship	Student/ Disabled*	Medical	Dental
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>
* Complete only for children age 19 or older, add additional sheet if necessary.								

<b>FLEXIBLE SPENDING ACCOUNTS (FSAs)</b>	
You may contribute a <b>maximum of \$5,000</b> a year to a Health or Dependent Care FSA (\$2,500 if married filing separately); <b>\$100 minimum for Health &amp; Dependent Care FSAs</b> . To take advantage of savings offered through the <b>FlexFund(s)</b> , you must enroll or re-enroll annually. For 2009, you have until March 15, 2010, to incur eligible healthcare expenses. You will have until April 30, 2010, to submit claims for services. The March 15 <sup>th</sup> deadline period does not apply to the Dependent Care Account. For 2009, you have until December 31, 2009, to incur eligible dependent care expenses.	
Account	Annual Contribution
Health Care FSA	\$
Dependent Care FSA	\$

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**BASIC & SUPPLEMENTAL GROUP TERM LIFE INSURANCE**

**Basic Life Insurance:** 100% University Paid

Beneficiary receives 1 times your annual salary for a Active Death

Beneficiary receives 2 times your annual salary for a Accidental Death & Dismemberment

**Supplemental Life Insurance:** 100% Employee paid (see rates below)

You may purchase Supplemental Group Term Life Insurance through Unum Provident in increments of \$10K, up to 5x your salary. The maximum amount of coverage is \$750k.

**Evidence of Insurability (EOI):** For amounts elected over \$200k please complete the EOI form, initially you will be set up with \$200k until EOI is approved.

**SUPPLEMENTAL GROUP TERM LIFE FOR FULL-TIME AND PART-TIME EMPLOYEES**

Employee and Spouse and Domestic Partner Rates*		Child Rates:*
Age Band	Monthly Rate per \$1,000 of Coverage	Monthly Rate per \$1,000 of Coverage: \$.103
<19	\$.040	
20 – 24	\$.050	
25 – 29	\$.050	*NOTE: The premium paid for <b>child coverage</b> is based on the cost of coverage for one child, regardless of how many children you have.
30 – 34	\$.050	
35 – 39	\$.080	
40 - 44	\$.120	
45 – 49	\$.220	
50 – 54	\$.390	
55 – 59	\$.660	*NOTE: <b>Employee and Spouse</b> , your rate will increase as you age and move to the next age band.
60– 64	\$.900	
65 – 69	\$1.62	
70 - 74	\$2.15	
75+	\$2.44	

**PLEASE PRINT LEGIBLY**

Add      Delete      Employee      Coverage Amount \$ \_\_\_\_\_ (in increments of \$10,000)

**DEPENDENT LIFE INSURANCE**

**If you elect Supplemental Group Term Life Insurance for yourself**, you can also buy life insurance for your spouse or domestic partner and/or dependent children in the amounts listed below. Coverage for your spouse or domestic partner cannot be greater than 50% of your Supplemental Group Term Life Insurance. You are the automatic beneficiary for any Dependent Life Insurance you purchase. **PLEASE PRINT LEGIBLY**

Add      Delete      Spouse, Coverage Amount \$ \_\_\_\_\_ (in increments of \$5,000)  
(maximum of \$375,000)

Add      Delete      Domestic Partner, Coverage Amount \$ \_\_\_\_\_ (in increments of \$5,000)  
(maximum of \$375,000)

Add      Delete      Child(ren), Coverage Amount \$ \_\_\_\_\_ (in increments of \$2,000)  
(maximum of \$10,000)

