

MEDICAL/DENTAL ENROLLMENT OPTION FORM

I. Premium Conversion Plan

125 participant:

a. I wish to participate in the Premium Conversion Plan and make contributions toward the cost of medical and dental insurance premiums with pre-tax dollars. I understand that my compensation will be reduced while this election is in effect, and the amount of the reduction will be the amount of the cost of the insurance premiums.

125 non-participant:

b. I decline participation in the Premium Conversion Plan. I understand that payment of any medical and dental insurance premiums will be with after-tax dollars.

II. Opt-Out Plan

I wish to waive medical and dental insurance coverage which the University provides for employees and spouses and/or dependents and hereby certify that medical insurance is provided elsewhere. I understand that except for a life event as defined by the IRS, I will only be allowed to opt back into coverage during the annual open enrollment period.

Name: _____

Date: _____

Signature: _____

Proof of Other Coverage Form

Eligible employees for the University Medical with Rx, Vision and Dental plan coverage who are also enrolled in a group medical plan sponsored by another employer, or are covered by a spouse, domestic partner, or parent may elect to Opt Out of their University sponsored medical plan coverage.

Once enrolled with coverage, an employee may only opt-out during annual Open Enrollment, or mid-year, following a Qualifying Event. A Qualifying Event is an event that causes either gain or loss of eligibility for other group medical coverage.

If you Opt Out of University coverage, you may enroll mid-year if you get married, acquire a new dependent, or lose your other medical coverage. To be eligible for this special enrollment, you must notify Human Resources within 30 days of the Qualifying Event.

In order to receive the conditional opt out amount of \$1,500 per year in 2022, please complete this form and attach a copy of the identification card from your other insurance coverage.

My other medical coverage insurance is provided through:

Employer Name or Plan: _____

The insurance carrier is: (for example, Highmark, Geisinger, etc.)

Name: _____

Date: _____

Signature: _____