

Carnegie Mellon 2009 Benefits Enrollment/Change Form for COBRA Participants

Read the Benefits Workbook for COBRA Participants for more information about benefit plan options, costs, and requirements.

COBRA Participant Information			Please print or type.	
Last Name	First Name	M.I.	Social Security Number	
Street Address			Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth - Month/Day/Year
City	State	Zip	Work Phone	Home Phone

Reason for Change

Changes during the year to medical, dental or vision coverage must be made within 31 days of a qualifying change in family or life status (see options below). No other changes are permitted until the annual Open Enrollment period.

DATE BECAME COBRA-ELIGIBLE OR DATE CHANGE OCCURED: _____	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Child became full-time student*
	<input type="checkbox"/> New COBRA participant / newly separated from the university	<input type="checkbox"/> Child age 19 to 23 is no longer full-time student
	<input type="checkbox"/> Marriage*	<input type="checkbox"/> Child age 23 is no longer eligible
	<input type="checkbox"/> Domestic Partner relationship established*	<input type="checkbox"/> Commencement of dependent's or spouse's/domestic partner's coverage under another plan
	<input type="checkbox"/> Divorce*	<input type="checkbox"/> Termination of dependent's or spouse's/domestic partner's coverage under another plan*
	<input type="checkbox"/> Domestic Partner relationship terminated*	<input type="checkbox"/> Moving away from the area
	<input type="checkbox"/> Death of spouse/domestic partner/dependent*	
	<input type="checkbox"/> Birth/Adoption of dependent*	
	<input type="checkbox"/> Other (subject to HR approval): _____	

TO BE COMPLETED BY HR:

DATE BENEFITS ENROLLMENT/CHANGE TO BECOME EFFECTIVE:

On the date of change

1st of month following change

* Documentation required to verify life/status event change. Contact Human Resources at 412-268-4747 to learn more about the supporting documentation that must be submitted or completed.

Medical Election Dental Election (through December 31, 2009)

<p>I elect the following medical carrier:</p> <input type="checkbox"/> UPMC <input type="checkbox"/> HealthAmerica <input type="checkbox"/> Highmark <input type="checkbox"/> Waive medical coverage	<p>I elect the following medical plan:</p> <input type="checkbox"/> PPO Option 1 <input type="checkbox"/> PPO Option 2 <input type="checkbox"/> PPO Option 3 <input type="checkbox"/> High Deductible PPO w/HRA <input type="checkbox"/> HMO (HealthAmerica, Highmark*) <input type="checkbox"/> Comprehensive (Highmark only)	<p>I elect the following dental plan:</p> <input type="checkbox"/> Concordia PPO Option 1 (Basic) <input type="checkbox"/> Concordia PPO Option 2 (Preferred) <input type="checkbox"/> Concordia DHMO <input type="checkbox"/> Waive dental coverage
<p>NOTE: MEDICAL AND PRESCRIPTION COVERAGE ARE LINKED. If you elect medical coverage, you must select a prescription option to cover the same individuals. If you opt out of medical coverage, you cannot elect prescription coverage.</p>		<p>I elect the following level of coverage:</p> <input type="checkbox"/> Individual <input type="checkbox"/> Family (employee, spouse, children) <input type="checkbox"/> Family (employee, DP, children)

* Note: Highmark HMO participants must elect the Highmark HMO prescription coverage.

Vision Election (through December 31, 2009)

<p>I elect the following level of coverage:</p> <input type="checkbox"/> Individual Employee <input type="checkbox"/> Employee & Child <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Domestic Partner <input type="checkbox"/> Family (employee, spouse, children) <input type="checkbox"/> Family (employee, DP, children)	<p>Prescription Election</p> <p>I elect the following prescription drug plan:</p> <input type="checkbox"/> Caremark Option A <input type="checkbox"/> Caremark Option B <input type="checkbox"/> Highmark HMO (for Highmark HMO participants only) <input type="checkbox"/> I waived medical coverage.	<p>I elect the following vision plan:</p> <input type="checkbox"/> Davis Vision Option 1 <input type="checkbox"/> VBA Option 1 <input type="checkbox"/> Davis Vision Option 2 <input type="checkbox"/> VBA Option 2 <input type="checkbox"/> Waive vision coverage <p>I elect the following level of coverage:</p> <input type="checkbox"/> Individual <input type="checkbox"/> Family (employee, spouse, children) <input type="checkbox"/> Family (employee, DP, children)
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Additional Medical Coverage Complete if you or your dependents are covered by medical insurance in addition to the Carnegie Mellon plan.

Insurance Company	Group Number	ID Number
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COBRA Participant & Dependent Information If electing level of coverage that includes spouse/domestic partner or children, complete this section.
 If covering more than 4 dependent children, make copies of side 2 of this form, complete additional dependent fields, and attach.

COBRA Participant	If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCP				If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCD		
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)	
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCP			If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check here if currently a patient of PCD		
Dependent 1	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)	
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Please complete a Student Certification Form, found at http://hr.web.cmu.edu , each semester enrolled.)		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCP		If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCD	
Dependent 2	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)	
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Please complete a Student Certification Form, found at http://hr.web.cmu.edu , each semester enrolled.)		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCP		If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCD	
Dependent 3	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)	
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Please complete a Student Certification Form, found at http://hr.web.cmu.edu , each semester enrolled.)		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCP		If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCD	
Dependent 4	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)	
Activity: Add to: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision Delete from: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Please complete a Student Certification Form, found at http://hr.web.cmu.edu , each semester enrolled.)		If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCP		If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required: <input type="checkbox"/> Check if currently a patient of PCD	
COBRA Participant Signature							
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 subject such person to criminal and civil penalties. I agree to comply with all provisions and procedures that govern administration of the Benefit Plans for Carnegie Mellon. I understand the university will make the necessary adjustment to my costs based on these changes/elections.							
Signature _____				Date _____			

Return to Human Resources -- Benefits Office; 5000 Forbes Avenue, Pittsburgh, PA 15213-3815.
 Questions? Contact the Human Resources Service Center at (412) 268-2047 or hrhelp@andrew.cmu.edu.