

# Carnegie Mellon

## 2009-2010 Benefits Enrollment/Change Form for Union Local 95

Read the Open Enrollment Summary for more information about benefit plan options, costs, requirements and tax implications.

Employee 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
E-mail address				

### Reason for Enrollment/Change

Changes during the year to benefit enrollments must be due to certain changes in employment, family or work status. No other changes are permitted until the annual Open Enrollment period.

<p>DATE OF EMPLOYMENT OR DATE CHANGE OCCURED: _____</p>	<input type="checkbox"/> New Hire <input type="checkbox"/> Marriage* <input type="checkbox"/> Domestic Partner relationship established* <input type="checkbox"/> Divorce* <input type="checkbox"/> Domestic Partner relationship terminated* <input type="checkbox"/> Death of spouse/domestic partner/dependent* <input type="checkbox"/> Birth/Adoption of dependent* <input type="checkbox"/> Other (subject to HR approval): _____	<input type="checkbox"/> Child became full-time student* <input type="checkbox"/> Child age 19 to 23 is no longer full-time student <input type="checkbox"/> Child age 23 is no longer eligible <input type="checkbox"/> Commencement of dependent's or spouse's/domestic partner's coverage under another plan <input type="checkbox"/> Termination of dependent's or spouse's/ domestic partner's coverage under another plan* <input type="checkbox"/> Return from leave
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**TO BE COMPLETED BY HUMAN RESOURCES:**

DATE BENEFITS ENROLLMENT/CHANGE TO BECOME EFFECTIVE:

On the date of change

1st of month following change

\*DOCUMENTATION REQUIRED. CONTACT HUMAN RESOURCES TO OBTAIN FURTHER INFORMATION.

### Medical Election

<p><b>I elect the following:</b></p> <p><input type="checkbox"/> HEALTHAMERICA HMO*</p> <p><input type="checkbox"/> Waive medical coverage (Waiver form required)</p> <p>• <i>Specify Primary Care Physician Code on reverse side</i></p>	<p><b>I elect the following level of coverage:</b></p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Employee &amp; Child</p> <p><input type="checkbox"/> Employee &amp; Children</p> <p><input type="checkbox"/> Employee &amp; Spouse</p> <p><input type="checkbox"/> Employee &amp; Domestic Partner (DP)</p> <p><input type="checkbox"/> Family (employee, spouse, children)</p> <p><input type="checkbox"/> Family (employee, DP, children)</p>
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### Group Term Life Insurance

**I elect the following amount of group term life insurance:**

You must elect at least basic coverage of 1 1/2-times salary or \$12,000, whichever is greater. After initial enrollment, you may increase to Optional Life Coverage due to an Open Enrollment Period or a qualified life or family status change. Maximum coverage allowed is \$500,000.

Basic (1 1/2-times salary or \$12,000, whichever is greater)

Optional Life Coverage

### Long-Term Disability

**I elect LTD coverage as follows:**  Basic LTD

*You must elect LTD coverage. Coverage will not begin until you have completed one year of full-time service.*

Additional information required on reverse side

## Employee & Dependent Information

If electing a level of coverage that includes spouse/domestic partner or children, complete this section.  
If covering more than 3 dependents, request Additional Dependents Form from the Benefits Office.

<b>Employee</b> Are you covered by other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Please select your HealthAmerica Primary Care Physician (PCP). Indicate PCP Code (not name) here:</b>  <input type="checkbox"/> Check here if currently a patient of PCP				
<input type="checkbox"/> <b>Spouse</b> <input type="checkbox"/> <b>Domestic Partner</b> Is your spouse/DP covered by other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
<b>Activity:</b> Add to: <input type="checkbox"/> Medical Delete from: <input type="checkbox"/> Medical		<b>Please select your HealthAmerica Primary Care Physician. Indicate PCP Code (not name) here:</b>  <input type="checkbox"/> Check here if currently a patient of PCP				
<b>Dependent 1</b> Is dependent covered by other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
<b>Activity:</b> Add to: <input type="checkbox"/> Medical Delete from: <input type="checkbox"/> Medical		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Proof of full-time student status is required. You will be contacted by our office asked to provide this information.) <input type="checkbox"/> Disabled Dependent		<b>Please select your HealthAmerica Primary Care Physician. Indicate PCP Code (not name) here:</b>  <input type="checkbox"/> Check here if currently a patient of PCP		
<b>Dependent 2</b> Is dependent covered by other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
<b>Activity:</b> Add to: <input type="checkbox"/> Medical Delete from: <input type="checkbox"/> Medical		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Proof of full-time student status is required. You will be contacted by our office asked to provide this information.) <input type="checkbox"/> Disabled Dependent		<b>Please select your HealthAmerica Primary Care Physician. Indicate PCP Code (not name) here:</b>  <input type="checkbox"/> Check here if currently a patient of PCP		
<b>Dependent 3</b> Is dependent covered by other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Date of Birth (Month/Day/Year)
<b>Activity:</b> Add to: <input type="checkbox"/> Medical Delete from: <input type="checkbox"/> Medical		<input type="checkbox"/> Dependent is age 19 up to 23 and a full-time student (Proof of full-time student status is required. You will be contacted by our office asked to provide this information.) <input type="checkbox"/> Disabled Dependent		<b>Please select your HealthAmerica Primary Care Physician. Indicate PCP Code (not name) here:</b>  <input type="checkbox"/> Check here if currently a patient of PCP		

## Employee Signature

I attest that the information I have provided is true and correct, and I agree to comply with all provisions and procedures that govern administration of the benefit election(s) indicated above. I understand that this agreement is irrevocable through June 30, 2010, unless I experience a qualified life or family status change as defined by the Plan. I authorize the university to make necessary adjustments in my pay based on the choices I have made.

Signature \_\_\_\_\_

\_\_\_\_\_ Date

Return to: Human Resources – Benefits & Compensation; 319 South Craig Street, Pittsburgh, PA 15213.  
Questions? Contact the Human Resources Service Center at 412-268-4747 or hrhelp@andrew.cmu.edu