

Read the LTD Benefits Workbook 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
Employee Type: <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Campus Police			E-mail address		

Reason for Enrollment/Change					
<p>Changes during the year to benefit enrollments must be made within 30 days of a qualifying change in family or life status (see options below). No other changes are permitted until the annual Open Enrollment period.</p>					
DATE LIFE EVENT OCCURED: _____	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Open Enrollment (OE) <input type="checkbox"/> Marriage* (documentation required) <input type="checkbox"/> Domestic Partner relationship established* (documentation required) <input type="checkbox"/> Divorce* (documentation required) <input type="checkbox"/> Domestic Partner relationship terminated* (documentation required) <input type="checkbox"/> Death of spouse/domestic partner/dependent* (documentation required) </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Birth/Adoption of dependent* (documentation required) <input type="checkbox"/> Child age 26 is no longer eligible for coverage <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* (documentation required) <input type="checkbox"/> Return from leave <input type="checkbox"/> Moving away from the area </td> </tr> <tr> <td colspan="2"> <input type="checkbox"/> Other (subject to HR approval): _____ </td> </tr> </table>	<input type="checkbox"/> Open Enrollment (OE) <input type="checkbox"/> Marriage* (documentation required) <input type="checkbox"/> Domestic Partner relationship established* (documentation required) <input type="checkbox"/> Divorce* (documentation required) <input type="checkbox"/> Domestic Partner relationship terminated* (documentation required) <input type="checkbox"/> Death of spouse/domestic partner/dependent* (documentation required)	<input type="checkbox"/> Birth/Adoption of dependent* (documentation required) <input type="checkbox"/> Child age 26 is no longer eligible for coverage <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* (documentation required) <input type="checkbox"/> Return from leave <input type="checkbox"/> Moving away from the area	<input type="checkbox"/> Other (subject to HR approval): _____	
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<input type="checkbox"/> Other (subject to HR approval): _____					
<p>TO BE COMPLETED BY HUMAN RESOURCES:</p> <p>DATE BENEFITS ENROLLMENT/CHANGE TO BECOME EFFECTIVE:</p> <input type="checkbox"/> On the date of change <input type="checkbox"/> 1st of month following change					
<p>* Documentation required to verify life/status event change. Contact Human Resources at 268-2047 to learn more about the supporting documentation that must be submitted or completed.</p>					

Medical Election	Dental Election	Prescription Election	Vision Election
<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/prescription coverage	<p>I elect the following medical plan:</p> <input type="checkbox"/> PPO Option 1 (Highmark/UPMC) <input type="checkbox"/> PPO Option 2 (Highmark/UPMC) <input type="checkbox"/> PPO Option 3 (Highmark/UPMC) <input type="checkbox"/> High Deductible PPO w/HRA (Highmark/UPMC) <input type="checkbox"/> HealthAmerica HMO <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>I elect the following level of coverage:</p> <input type="checkbox"/> Individual <input type="checkbox"/> Family (employee, spouse, children) <input type="checkbox"/> Family (employee, domestic partner, children)
<p>I elect the following level of coverage:</p> <input type="checkbox"/> Individual Employee <input type="checkbox"/> Individual & Child <input type="checkbox"/> Individual & Children <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Individual & Domestic Partner <input type="checkbox"/> Family (individual, spouse, children) <input type="checkbox"/> Family (individual, domestic partner, children)	<p>I elect the following prescription drug plan:</p> <input type="checkbox"/> Caremark Option A <input type="checkbox"/> Caremark Option B <input type="checkbox"/> Waive medical/prescription 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, domestic partner, children)

Additional information required on reverse side.

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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Participant & Dependent Information Complete if covering spouse/domestic partner or children. Copy this page if needed for additional dependents.

LTD 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		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		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		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		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		

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 pay based on these changes/elections.

Signature _____

Date _____

Return to: Human Resources – Benefits Office, 5000 Forbes Avenue, Pittsburgh, PA 15213.

Questions? 412-268-2047 or hrhelp@andrew.cmu.edu