BENEFITS ENROLLMENT FORM

WAGNER COLLEGE

☐ New Hire | ☐ Open Enrollment | ☐ Qualifying Event | ☐ Cancellation

A. Employee Personal Information

Name (Last, First, MI)					Social Security Number	
Street Address			City		State	Zip
Home Phone	Work Phone	❑ Male ❑ Female	❑ Married ❑ Single	❑ Divorced ❑ Separated	Date of Birth / /	Date of Hire / /

B. Medical Coverage

Choose ***ONE*** Plan:	Single	Employee + Spouse	Employee + Children	Family	Monthly Deduction	
UMR $0 Deductible PPO Plan	❑	❑	❑	❑	Employee Employee + Spouse Employee + Children Family	$219.56 $455.73 $421.31 $612.38
UMR EPO Plan	❑	❑	❑	❑	Employee Employee + Spouse Employee + Children Family	$153.83 $334.18 $302.36 $456.19
Waive Plan	❑					

C. Dental Coverage

Choose ***ONE*** Option:	Single	Employee + Spouse	Employee + Children	Family	Monthly Deduction	
Cigna High Plan	❑	❑	❑	❑	Employee Employee + Spouse Employee + Children Family	$44.41 $105.17 $109.55 $122.39
Cigna Low Plan	❑	❑	❑	❑	Employee Employee + Spouse Employee + Children Family	$8.04 $26.88 $29.27 $44.80
Waive Plan	❑					

D. Vision Coverage

Choose ***ONE*** Option:	Single	Employee + Spouse	Employee + Children	Family	Monthly Deduction	
VSP Vision Plan	❑	❑	❑	❑	Employee Employee + Spouse Employee + Children Family	$11.90 $19.04 $19.43 $31.33
Waive Plan	❑					

The benefit elections you make will remain in effect through December 31, 2019. You will not be able to change your elections during the plan year unless you experience a qualified change in status as defined by federal law.

E. Dependent Information

You must indicate dependents you want covered by your health or dental plans. Attach separate sheet for additional children.

Last Name, First Name, MI	Sex	Date of Birth	Social Security Number	Coverage Medical	Dental	Vision
Spouse	❑Male ❑Female	/ /		❑	❑	❑
Child	❑Male ❑Female	/ /		❑	❑	❑
Child	❑Male ❑Female	/ /		❑	❑	❑
Child	❑Male ❑Female	/ /		❑	❑	❑
Child	❑Male ❑Female	/ /		❑	❑	❑
Child	❑Male ❑Female	/ /		❑	❑	❑
Child	❑Male ❑Female	/ /		❑	❑	❑

F. Medicare Questions

Are you or your dependent(s) covered by Medicare? ❑ No ❑ Yes (If Yes, please complete below)

Employee		Dependents	
Medicare Part A HIC#	Start Date	Medicare Part A HIC#	Start Date
Medicare Part B? ❑No ❑Yes (If Yes…)	Start Date	Medicare Part B? ❑No ❑Yes (If Yes…)	Start Date

G. Other Insurance Information

(If you or your dependents have other group medical or dental coverage, please answer the following:)

Medical ❑ Employee ❑ Dependents ❑ N/A	Dental ❑ Employee ❑ Dependents ❑ N/A
Insurance Company:	**Insurance Company:**
Group Number:	**Group Number:**
Covered Dependents:	**Covered Dependents:**

I have read the above statements and represent they are true to the best of my knowledge. If applicable, the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I authorize my employer to deduct from my pay the necessary premiums (if any) to be withheld through payroll deduction and, where allowed, on a pre-tax basis, in equal installments throughout the plan year. This authorization is to remain in effect until I notify the company in writing to the contrary. Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, clinic, other medical or medically related facility, government agency, or other person or firm to provide information including copies of records concerning advice, care or treatment provided to me and/or my dependents including, without
limitation, information relating to mental illness, use of drugs or alcohol, to the Company representatives involved in evaluating, determining or administering claims for insurance benefits for my dependents and me.

The benefit elections you make during the Open Enrollment period will remain in effect through December 31, 2019. You will not be able to change your elections during the plan year unless you experience a qualified change in status as defined by federal law.

Employee Signature

Signature	Date

Employer Verification (To be completed by employer. Employer Signature Required.)

Signature		Date
Effective Date	Policy Number	Plan Code(s)