Washington University in St. Louis

Postdoctoral Research Appointee 2017 Enrollment/Change Form

Medical School Benefits-
Campus Box 8002/Fax (314) 362-2500

Danforth Campus Benefits-
Campus Box 1190/Fax (314) 935-8198

REFER TO INSTRUCTION PAGE BEFORE COMPLETING FORM

(A) PERSONAL INFORMATION

Last Name	First Name	MI	WUSTL ID - Required

(B) ENROLLMENT/CHANGE

Status changes are effective the first of the month following the date of event

Reason For Enrollment/Change:
- ❑ **New Appointment**
- ❑ **Open Enrollment**
- ❑ **Family Status Change** **(check corresponding box below)**

Appointment Date ____________
Effective Date ____________
Date of Event ____________

- ❑ Birth or Adoption*
- ❑ Change of Employment Status
- ❑ Death
- ❑ Dependent No Longer Eligible
- ❑ Divorce
- ❑ Loss of other coverage
- ❑ Marriage
- ❑ Spouse's Open Enrollment
- ❑ Termination/Commencement of Appointment

(C) HEALTH INSURANCE

I Elect To:	Plan Type: (UHC Networks)	Coverage Level:
❑ Enroll in Health/Dental	❑ HMO/EPO	❑ Individual Only
❑ Enroll in Advantica Dental Only	❑ POS	❑ Individual + Child/ren
❑ Change Plan or Coverage	❑ Excel PPO	❑ Individual + Spouse/Partner
❑ Waive Health/Dental Coverage	❑ Basic PPO	❑ Family

(D) VISION BUY-UP OPTION (You must be enrolled in a Health Plan to participate in the Vision Buy-Up Option)

I Elect To:
- ❑ Enroll in the Vision Buy-Up Option
- ❑ Waive the Vision Buy-Up Option

(E) DEPENDENT INFORMATION

List only dependents to be covered.

Action	Dependent Relationship***	Date of Birth	Name Last (if different), First, MI	Gender	Is Dependent Disabled?
❑ Add ❑ Delete	❑ Spouse ❑ Domestic Partner ††	___/___/___	**NAME** **SSN**	❑ Male ❑ Female	❑ Yes ❑ No
❑ Add ❑ Delete	Child-1	___/___/___	**NAME** **SSN**	❑ Male ❑ Female	❑ Yes ❑ No
❑ Add ❑ Delete	Child-2	___/___/___	**NAME** **SSN**	❑ Male ❑ Female	❑ Yes ❑ No
❑ Add ❑ Delete	Child-3	___/___/___	**NAME** **SSN**	❑ Male ❑ Female	❑ Yes ❑ No

(F) AUTHORIZATION

My signature below indicates that I have received, read and understand the materials describing the options available to me. I hereby certify that all the information provided is true and correct to the best of my knowledge. I realize that I am making a binding election for the coming calendar year, which can only be changed if I experience a family status change. I understand Washington University reserves the right to request additional information on family status changes at any time. I hereby authorize Washington University to deduct the contribution amounts and/or premiums directly from my paycheck.

SIGNATURE: **DATE:**

HR OFFICE USE ONLY	Entered by	Date Entered	Effective Date

Washington University
Postdoctoral Research Appointee
Benefits Enrollment/Change Form Instructions

For plan details visit the HR website at http://hr.med.wustl.edu or http://hr.wustl.edu

A) PERSONAL INFORMATION

Please print legibly and complete all information.

(B) ENROLLMENT/CHANGE

Check new appointment or status change box. If rehired, check new hire box. Enter date of appointment or event date of status change. For status changes, choose the appropriate change from the list. Forms must be received within 31 days of date of hire, rehire or status change (62 days for birth or adoption).
*Include a copy of adoption papers with date of custody.

**Include a copy of page of decree with date of divorce, name, SSN and address of ex-spouse

†Ending your relationship with a domestic partner is a qualifying event to remove the individual from your health/dental plan. However, should you renew your relationship with the same partner, you must wait until the next open enrollment to re-enroll him/her as a covered dependent.

(C) HEALTH INSURANCE

Choose election, plan type, and coverage level. **Postdoctoral employee** premiums are withheld on a pre-tax basis, however special tax rules apply for domestic partners. **Postdoctoral non-employees** receive a reimbursement stipend toward the cost of health insurance. Enrollment in health plan automatically includes enrollment in Advantica Dental plan. If enrolling in “Advantica Dental Only”, skip *Plan Type*. If enrolled under spouse’s coverage at the University check waive box. By waiving health and dental coverage, you acknowledge that changes may be made only in the event of a family status change or during Open Enrollment.

(D) VISION BUY-UP OPTION

If you elect to enroll in this optional insurance, please check the box. (Note: Must be enrolled in a Health Plan to enroll in the Vision Buy-Up Option).

(E) DEPENDENT INFORMATION

Complete section D only if you are adding or deleting dependents from health/dental coverage. Eligible dependents are a spouse or a domestic partner; natural, adopted or step children, or children for whom you are the legal guardian, who are age 26 or less and not eligible for coverage under their own employer-sponsored health plan. Your spouse or domestic partner must reside with you. A child for whom a Qualified Medical Child Support Order or court order requires you to provide healthcare coverage also qualifies as an eligible dependent. An unmarried child age 26 or older who is incapable of self-support because of mental or physical disability and is dependent upon you for support and maintenance is also eligible, as long as the disability existed prior to their reaching the age of 26 and the child was covered as your dependent under the Plan immediately prior to reaching age 26. **The University reserves the right to periodically request proof of eligibility.**

A completed Dependent Verification Affidavit is required when covering dependents. ††When adding a Domestic Partner, you must also complete a Domestic Partner Verification Form (available on the HR website at http://hr.med.wustl.edu or http://hr.wustl.edu) and provide proof of residency for your domestic partner with your enrollment form.

(F) AUTHORIZATION

Please sign and date form. Unsigned forms will be returned to postdoctoral appointee unprocessed. **Submit completed forms to: Medical School Benefits-Campus Box 8002 or fax to (314) 362-2500. Danforth Benefits-Campus Box 1190 or fax to (314) 935-8198.**

Be sure to check your next payroll advice on HRMS Self Service for accuracy.
For Self Service assistance contact the Help Desk at 935-5707