

BENEFIT/ENROLLMENT CHANGE FORM		HUMAN RESOURCES ONLY: Entered By: _____ Date: _____	
Date of Hire: _____ University ID: _____		Employee Name: _____	
Status: <input type="checkbox"/> 9-Month <input type="checkbox"/> 12-Month		Address: _____	
Select One:		City/State/Zip: _____	
<input type="checkbox"/> New Hire	<input type="checkbox"/> Legal Marriage/Divorce	Home Phone: _____	Work Phone: _____
<input type="checkbox"/> Birth/Adoption/Foster Care		Email Address: _____	
<input type="checkbox"/> Ineligible Dependent	<input type="checkbox"/> Open Enrollment	SSN: _____	Date of Birth: _____
<input type="checkbox"/> Qualified Medical Child Support Order		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undeclared	Marital Status: _____
<input type="checkbox"/> Other Status Change: _____		Is your spouse employed by Mississippi State University?	
Date of Qualifying Event: _____		<input type="checkbox"/> No <input type="checkbox"/> Yes Provide name: _____	
University employees are paid twice a month. Premium deductions for 12-month employees occur over 24 pay periods. 9-month faculty members can choose to have deductions occur over 24 pay periods or 18 pay periods. Pay Mode: Semi-Monthly			

Spouse/Dependent Information - List all dependents you wish to cover or drop from the insurance plans you have selected. Check all benefits that apply.					Disabled Dependent (Check if yes)	Add/Drop/Change/ No Change	Dental	Vision	UNUM Life and AD&D
Name (Last, First, MI) (Current Legal Name Only)	Social Security Number	M/F	Birth Date	Relationship					
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dental – Delta Dental	
Section 125 Cafeteria Plan Group # 25-01125	
Employee Only	Family
Semi-Monthly Rates	Semi-Monthly Rates
Low Plan (0002) <input type="checkbox"/> \$14.41	<input type="checkbox"/> \$30.07
High Plan (0001) <input type="checkbox"/> \$20.79	<input type="checkbox"/> \$43.25
Are you or your family member(s) currently covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide the name of the participant(s) with other coverage: _____	
<input type="checkbox"/> Waive Coverage	
FOR HUMAN RESOURCES ONLY	
Effective Date: _____	

Vision – Davis Vision	
Section 125 Cafeteria Plan Group # 7870	
Semi-Monthly Rates	
<input type="checkbox"/> Employee Only	\$4.17
<input type="checkbox"/> Employee + 1	\$7.48
<input type="checkbox"/> Family	\$11.63
<input type="checkbox"/> Waive Coverage	
FOR HUMAN RESOURCES ONLY	
Effective Date: _____	

Supplemental Term Life and AD&D – UNUM - Premiums are withheld 12-month / 9-month

**Guarantee Issue (GI) only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability (EOI) must be provided and UNUM has the right at that time to refuse the request for coverage.*

<u>Employee Life / AD&D Coverage</u>	<u>Spouse Life Coverage</u>	<u>Dependent Child(ren) Life Coverage</u>
Choose from \$10,000 to \$750,000 in \$10,000 increments, up to 5 times your annual wage. <i>*Employee Coverage amounts above \$200,000 require an EOI Form</i>	Get up to \$500,000 of coverage in \$5,000 increments. Spouse coverage cannot exceed 100% of the employee's coverage. <i>*Amounts above \$100,000 require Evidence of insurability.</i>	Get up to \$10,000 of coverage in \$2,000 increments. One policy covers all of your children until their 26 th birthday. <i>* The maximum benefit for children live birth to 6 months is \$1,000.</i>
<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Elect Coverage
Tobacco User: <input type="checkbox"/> Yes <input type="checkbox"/> No (used in the last 12 months)	Tobacco User: <input type="checkbox"/> Yes <input type="checkbox"/> No (used in the last 12 months)	Tobacco User: <input type="checkbox"/> Yes <input type="checkbox"/> No (used in the last 12 months)
Amount Requested: \$ _____	Amount Requested: \$ _____	Amount Requested: \$ _____
<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage

Spouse Name (if coverage is selected)	Spouse Date of Birth (if coverage is selected)

Beneficiary Designation: *If you do not designate a beneficiary, the payment of benefits will default to provisions of the contract.

Name (Last Name, First, MI):	Relation to You:	Benefit %:

If the beneficiary(ies) named above are not living, then pay:

Delayed Effective Date: **Employee:** Insurance will be delayed for Employees not actively at work until the date they return to work. Regularly scheduled vacation time is considered active employment. **Dependent:** Coverage for totally disabled dependents will be delayed until the first of the month following the date the individual is no longer totally disabled.

Policy Limitations and Exclusions: I understand all the policy exclusions and limitations listed in the certificate of coverage. If electing to participate in any of the benefit plans mentioned above, I authorize the required payroll deductions. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that if I cancel/decline participation, I may join the Plan at a specified later date; however, I will be required to provide evidence of insurability at my own expense, and the insurance company may refuse my request. In the event of any variations between this form and the Plan document, the terms of the Plan document will prevail.

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Employee Coverage Amount: \$ _____	Spouse Coverage Amount: \$ _____	Coverage Amount: \$ _____
Cost: \$ _____	Cost: \$ _____	Cost: \$ _____
Effective Date: _____	Effective Date: _____	Effective Date: _____

Annual Salary: \$ _____

Long-Term Disability (LTD) – UNUM

Premiums are withheld 12-Month / 9-Month

You may elect disability coverage of 25% (Non-Integrated) or 60% (Integrated) of your monthly earnings up to \$10,000 per month, until age 65. Benefits are payable after a 90- or 180- day elimination period subject to review by UNUM. *Pre-Existing Limitations may apply.

**Guarantee Issue only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability will be required and UNUM has the right at that time to refuse the request for coverage.*

Plan 1 – 60% integrated benefit with 90 day elimination period: 60% of monthly earnings to a maximum benefit of \$10,000 per month.

Plan 2 – 25% non-integrated benefit with 90 day elimination period: 25% of monthly earnings to a maximum benefit of \$10,000 per month.

Plan 3 – 60% non-integrated benefit with 180 day elimination period: 60% of monthly earnings to a maximum benefit of \$10,000 per month.

Plan 4 – 25% non-integrated benefit with 180 day elimination period: 25% of monthly earnings to a maximum benefit of \$10,000 per month.

<input type="checkbox"/> I Elect Plan #: _____ <input type="checkbox"/> Waive/Cancel Coverage	FOR HUMAN RESOURCES ONLY	
	Base Annual Earnings: \$ _____	
	Position Title: _____	
	Hours Worked per Week: _____	Effective Date: _____

I acknowledge that I voluntarily and without coercion made elections/waivers as documented on this form. I understand my salary will be reduced by the amount(s) shown on this enrollment form for the eligible benefit options I have elected and since premiums are collected one month in advance, the University will collect premiums in arrears as an additional payroll deduction. If my salary reduction for the elected insurance benefit(s) increases or decreases while this agreement remains in effect, my salary will automatically be adjusted to reflect the change.

PRE-TAX ELECTIONS

I understand that eligible benefits offered by Mississippi State University are available to me through payroll deduction under the Pre-Tax Benefit Plan as provided under Section 125 of the Internal Revenue Code (IRC). I understand that I must complete an application for coverage for each election. Cafeteria Plan elections will be irrevocable for the Plan Year except for modifications due to a qualifying event (divorce, marriage, death of spouse/dependent child, birth/adoption of a child, change of employment status of me or my spouse, cost of coverage/change, HIPAA special enrollment rights, or other event specified by the IRS) provided I complete enrollment paperwork to request the election change and submit to the Human Resources Department no later than 60 days after the date of the qualifying event. Prior to each Plan Year, I will be given the opportunity to change my benefit election(s). If I fail to complete and submit to the Human Resources Department a new election form within the allotted enrollment period, I understand my election will remain the same.

I understand pre-tax elections are not eligible as deductions for federal or state income tax purposes and may reduce social security benefits. My employer may reduce or cancel the amount of my salary reduction or otherwise modify this agreement in order to satisfy certain provisions of the Internal Revenue Code.

I understand my elected benefits will cease upon separation of employment but I will be afforded an opportunity to continue coverage via COBRA for qualifying plans.

If I participate in the dependent care plan, reimbursements cannot exceed the amount incurred during the Plan Year. If I participate in an unreimbursed medical expense plan, I may be reimbursed for qualifying out-of-pocket medical expenses. Claims must be filed with Southern Administrators and Benefit Consultants (SABC) no later than April 15 of the following calendar year.

I understand that privacy statements are available via the University website at www.hrm.msstate.edu/benefits. If I do not have access to the internet, I can request a paper copy from the Human Resources Department. As an employee, I acknowledge that I am the subscriber of coverage, and that the Privacy Policy is also applicable to my spouse and/or my dependents. I also understand I will be reissued the Privacy Statement, as a material modification is made, and every three years, via the University’s email system.

This election and salary reduction agreement is subject to the terms of my employer’s cafeteria plan document.

EMPLOYEE SIGNATURE: _____

DATE SIGNED: _____