For Employees Represented by 32BJ

Benefits Enrollment Form

Benefits supporting
your personal health
and family needs

www.bu.edu/hr

BOSTON
UNIVERSITY

For Employees Represented by 32BJ

Benefits Enrollment Form

Instructions: Please complete Section 1 and any other section, as appropriate. Sign and date this form in Section 11.

TYPE OF ENROLLMENT
☐ Open Enrollment
☐ New Hire
☐ Change
☐ Cancellation

FOR HEALTH PLAN USE ONLY

Effective Date of Coverage:

1. Employee Data (please print) ☐ Change in address

NAME (LAST, FIRST, M.I.) **BU ID NUMBER** **DATE OF BIRTH**

ADDRESS **STREET** **CITY** **STATE** **ZIP CODE**

HOME PHONE **WORK PHONE** **SEX (M/F)** **MARITAL STATUS (SINGLE, MARRIED, DIVORCED, WIDOWED, SEPARATED)**

2. Health Plan (pre-tax)

(a) Choose your Health Plan Option:

☐ BCBS PPO ☐ BCBS Network Blue New England (Indicate your primary care physician in Section 4 below)*

☐ BU Health Savings Plan with HSA (Indicate your HSA contribution amount below)** ☐ No Coverage

(b) Choose your Level of Coverage:

☐ Employee only ☐ Employee plus child(ren) ☐ Employee plus spouse ☐ Family

**If you enroll in the BU Health Savings Plan with HSA, please elect your contribution amount for the Health Savings Account.

I elect to contribute $_____ per pay period to my Health Savings Account through Fidelity Investments (not to exceed IRS limits).
I understand that I cannot participate in both a Health Savings Account and a Health Care Flexible Spending Account in the same plan year.

3. Dental Health Plan (pre-tax)

(a) Choose your Dental Plan Option:

☐ BU Dental Health Center Plan ☐ Dental Blue Freedom Plan ☐ No coverage

(b) Choose your Level of Coverage:

☐ Employee only ☐ Employee plus child(ren) ☐ Employee plus spouse ☐ Family

4. Health and Dental Plan Information (Please print. Be sure to check the appropriate boxes for the coverages you elect for your dependents; you may add any additional dependents on a separate sheet of paper.)

NAME (LAST IF DIFFERENT, FIRST, M.I.)	DATE OF BIRTH (MM/DD/YY)	SEX (M/F)	SOCIAL SECURITY NUMBER	HEALTH	DENTAL	PCP NAME AND LOCATION*
EMPLOYEE						
SPOUSE						
CHILD						
CHILD						
CHILD						

5. Supplemental Life Insurance (after-tax)

☐ One times salary ☐ Two times salary ☐ Three times salary ☐ Four times salary ☐ Five times salary ☐ No coverage

Supplemental Life Insurance is in addition to the Basic Life Insurance (one times your annual base salary) that the University provides at no cost to you. Coverage will be rounded to the next higher $10,000. You must provide evidence of insurability for coverage above $500,000.

6. Dependent Life Insurance (after-tax)

For your spouse:
From $10,000 to $100,000 in $10,000 increments, not to exceed three times your salary. Evidence of insurability is required for coverage above $20,000.
I elect ☐ $_____ ,000 ☐ No coverage

For each dependent child under age 19:
I elect ☐ $5,000 ☐ $10,000 ☐ No coverage

7. Personal and Family Accident Insurance (pre-tax)

Type of coverage: ☐ Individual ☐ Family ☐ No coverage

Amount of coverage: $_____ ,000 (must be a multiple of $10,000)

The maximum amount of coverage is $350,000. Amounts in excess of $150,000 may not exceed 10 times your annual salary. Your family is covered in proportion to the amount of coverage you select.

8. Flexible Spending Accounts (pre-tax) (for employees with an annual salary of $10,000 or more)

Health Care Account:

☐ I elect to contribute $_____ in total to my Health Care Account (subject to IRS limits) until December 31.

Dependent Care Account:

☐ I elect to contribute $_____ in total to my Dependent Care Account (subject to IRS limits) until December 31.

Decline Participation:

☐ I do not wish to participate this year.

I understand that pre-tax deductions will be made from my paycheck in equal amounts per pay period as indicated above, and that I will forfeit money not used for qualifying expenses incurred by December 31 for the Dependent Care Account; March 15 of the next plan year for the Health Care Account.

9. Beneficiary Designation (please print)

Complete this section to name or update your beneficiary designation. It will apply to your Life and Accident coverages.

BENEFICIARY NAMES (LAST, FIRST, M.I.)	RELATIONSHIP	% OF BENEFIT

CONTINGENT BENEFICIARY NAMES	RELATIONSHIP	% OF BENEFIT

If you have more beneficiaries, or wish to designate separate beneficiaries for each plan, please attach a separate sheet with the above information. You may change your beneficiary(ies) at any time by completing a form available in the Benefits Section at www.bu.edu/hr. You are automatically the beneficiary of any supplemental life insurance or family accident insurance you elect for your dependents.

10. Other Coverage

Do you or your dependent(s) have additional health coverage? ☐ Yes ☐ No
If yes, provide name of carrier, address, and contract number.

Do you or your dependent(s) have additional dental coverage? ☐ Yes ☐ No
If yes, provide name of carrier, address, and contract number.

11. Signature

I certify below that I have completed this form to the best of my knowledge, and I understand the following:

- My coverage elections on this form cannot be revoked or modified during the year unless I have a qualifying change in status as defined by the IRS; I may, however, change my coverage elections during the next open enrollment period.
- My pay will be reduced by the amount of any required contributions noted for the coverages elected where the contributions are pre-tax.
- I acknowledge receiving a copy of the Faculty & Staff Benefits Handbook for my employee classification and reading the descriptions of the benefit plans in which I am enrolling. I also understand any limitations or restrictions on coverage or benefits under these benefit plans as described in the Faculty & Staff Benefits Handbook. If I have enrolled in a Health Care or Dependent Care Flexible Spending Account, I agree to the provisions printed on the reverse side of this form.

I give permission to the health plan I select to obtain and/or examine my medical records (and/or those of my dependent(s)) from any health care practitioner or institution in which care is provided while a member, to the extent permitted by law; and I (we) understand the benefits and agree to the provisions as described in the Plan document.

SIGNATURE DATE

Please return this Enrollment Form to BU Human Resources, 25 Buick Street, Boston, MA 02215 or fax to 617-353-6704.

Health Care and/or Dependent Care Flexible Spending Account Agreement

The following agreements apply if I have enrolled in a Health Care and/or a Dependent Care Flexible Spending Account.

- Although BU will try to help me identify eligible expenses for reimbursement, the University cannot be held responsible if the IRS rules that a reimbursement expense does not qualify or if some other requirement is not met. I agree to reimburse the University for any liability it may incur for failure to withhold federal and state income tax or Social Security tax up to the amount of additional tax owed by me.

- If I leave employment with BU, I may still submit claims for reimbursement of dependent care and medical care expenses incurred through my termination date, provided such claims are submitted no later than March 31 of the following calendar year. Any account balances remaining after that date will, by law, be forfeited.

- In accordance with federal law, when submitting dependent care claims for reimbursement I must include my care provider's tax identification number or Social Security number.

- If I terminate employment during this calendar year and have received a greater amount of health care reimbursement benefits than I have contributed to my account, I agree to continue contributing to such account during the balance of this calendar year in accordance with my enrollment contribution agreement in Section 8 of the Enrollment Form, until such excess has been eliminated. Furthermore, I authorize BU to offset against my final paycheck any excess of reimbursement benefits received over contributions paid into my account.

BU Human Resources