Benefits Enrollment Form

Benefits supporting your personal health and family needs

www.bu.edu/hr



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

 \square Open Enrollment

☐ New Hire☐ Change

☐ Cancellation

FOR HEALTH PLAN USE ONLY

Effective Date of Coverage:

AME (LAST, FIRST, M.I.)			DATE OF BIRTH					
DDRESS	STREET		CITY		STATE	ZIP CODE		
OME PHONE	WORK PHONE	SEX (M/F)	MARI	TAL STAT	US (SINGLE, MARRIED, DIV	ORCED, WIDOWED	, SEP/	4RA
P. Health Plan (pre-tax a) Choose your Health Pla BCBS PPO BU Health Savings Plan	an Option:	ugur USA gantribut	ion amount ha	Jow)**	□ Na Covere			
b) Choose your Level of C					☐ No Coveraş	ge		
*If you enroll in the BU He	ealth Savings Plan wi	th HSA, please elect	your contribu	ıtion am	ount for the Health Sav	vings Account.		
elect to contribute \$ understand that I cannot								
B. Dental Health Plan a) Choose your Dental Pla ☐ BU Dental Health Cent	an Option:	al Blue Freedom Pla	ın 🗆	No cov	erage			
o) Choose your Level of C \Box Employee only \Box \Box	overage: Employee plus child(ren) 🗌 Employee	e plus spouse		Family			
. Health and Dental	Plan Information	(Please print. Be su	ire to check th	a annro	inriate hoves for the co	voragos vou olo	- L . C -	r vo
				ie appie	priate boxes for the co	verages you ele	Ct 10	. , -
ependents; you may add	any additional deper	idents on a separate			priate boxes for the co	verages you ele	CT TO	. , .
	any additional deper	dents on a separate				verages you ele	CT 10	
NAME	any additional deper	dents on a separate	sheet of pape	er.)	SOCIAL SECURITY		Ct 10	. , ,
NAME	any additional deper	dents on a separate	sheet of pape	er.)				
NAME LAST IF DIFFERENT, FIRST, M.I.)	any additional deper	dents on a separate	sheet of pape	er.)			НЕАЦТН	DENTAL
NAME LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE	any additional deper	dents on a separate	sheet of pape	er.)				
NAME (LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE SPOUSE	any additional deper	dents on a separate	sheet of pape	er.)				
NAME (LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE SPOUSE CHILD	any additional deper	dents on a separate	sheet of pape	er.)				
NAME (LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE SPOUSE CHILD	any additional deper	dents on a separate	sheet of pape	er.)				
ependents; you may add NAME (LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE SPOUSE CHILD CHILD CHILD	any additional deper	dents on a separate	sheet of pape	er.)				
NAME (LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE SPOUSE CHILD CHILD			sheet of pape	er.)				
NAME (LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE SPOUSE CHILD CHILD CHILD CHILD	Insurance (after-ta	ax)	DATE OF BIRTH (MM/DD/YY)	SEX (M/F)	SOCIAL SECURITY	NUMBER	НЕАГТН	DENTAL
NAME (LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE SPOUSE CHILD CHILD CHILD CHILD CHILD One times salary	Insurance (after-ta	ax) □ Three times sala	DATE OF BIRTH (MM/DD/YY) ary	SEX (M/F)	social security	NUMBER	/оз с	Vera
NAME (LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE SPOUSE CHILD CHILD CHILD CHILD ONE TIMES SALARY Upplemental Life Insurance	Insurance (after-ta Two times salary e is in addition to the B	ax) □ Three times sala	DATE OF BIRTH (MM/DD/YY) ary Four one times your	sex (M/F)	social security alary	NUMBER salary	/оз с	Vera
NAME (LAST IF DIFFERENT, FIRST, M.I.) EMPLOYEE SPOUSE CHILD CHILD CHILD One times salary upplemental Life insurance coverage will be rounded to	Insurance (after-ta Two times salary e is in addition to the E to the next higher \$10	ax) □ Three times sala	DATE OF BIRTH (MM/DD/YY) ary Four one times your	sex (M/F)	social security alary	NUMBER salary	/оз с	Vera
EMPLOYEE SPOUSE CHILD CHILD CHILD One times salary upplemental Life Insurance Coverage will be rounded to be provided by the control of	Insurance (after-ta Two times salary e is in addition to the E to the next higher \$10 urance (after-tax)	ax) ☐ Three times sala Basic Life Insurance (0,000. You must pro	DATE OF BIRTH (MM/DD/YY) ary Four one times your	times s	social security alary	salary \(\sigma\) No iversity provides ove \$500,000.	O CO Co at no	vera

7. Personal and Family Acciden	t Insurance (pre-tax)			
Type of coverage: Individual	☐ Family ☐ No	o coverage		
Amount of coverage: \$,000 (m	ust be a multiple of \$10,0	00)		
The maximum amount of coverage is \$ Your family is covered in proportion to			may not exceed 10 times yo	our annual salary.
8. Flexible Spending Accounts	(pre-tax) (for employees	with an annual sal	ary of \$10,000 or more)	
Health Care Account: I elect to contribute \$	in total to my Health Car	e Account (subjec	t to IRS limits) until Decem	nber 31.
Dependent Care Account: ☐ I elect to contribute \$	in total to my Dependent	Care Account (su	ubject to IRS limits) until De	ecember 31.
Decline Participation: ☐ I do not wish to participate this year	r.			
I understand that pre-tax deductions will be for qualifying expenses incurred by December 1				
9. Beneficiary Designation (plea				
Complete this section to name or upda BENEFICIARY NAMES (LAST, FIRST, M.I.)	te your beneficiary design	nation. It will apply RELATIONSHIP	y to your Lite and Accident	coverages. % OF BENEFIT
CONTINGENT BENEFICIARY NAMES		RELATIONSHIP		% OF BENEFIT
If you have more beneficiaries, or wish a You may change your beneficiary(ies) the beneficiary of any supplemental life.	at any time by completing	g a form available	in the Benefits Section at w	ww.bu.edu/hr. You are automatically
10. Other Coverage				
Do you or your dependent(s) have add If yes, provide name of carrier, address		☐ Yes ☐ I	No	
Do you or your dependent(s) have add If yes, provide name of carrier, address		☐ Yes ☐ I	No	
11. Signature				
I certify below that I have completed the My coverage elections on this form of IRS; I may, however, change my coverence My pay will be reduced by the amount I acknowledge receiving a copy of the efit plans in which I am enrolling. I also in the Faculty & Staff Benefits Handb sions printed on the reverse side of the	annot be revoked or modi age elections during the r at of any required contribu Faculty & Staff Benefits I so understand any limitati ook. If I have enrolled in a	fied during the yenext open enrollmutions noted for the Handbook for my cons or restrictions	ar unless I have a qualifying ent period. le coverages elected where employee classification and s on coverage or benefits ur	the contributions are pre-tax. I reading the descriptions of the ben- nder these benefit plans as described
I give permission to the health plan I secare practitioner or institution in which agree to the provisions as described in	care is provided while a			

SIGNATURE

DATE

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.