



# Benefits Enrollment Form

Benefits supporting your personal health and family needs

**If You Live In  
Massachusetts**

You are required under state law to be enrolled for medical coverage. If you decline medical coverage at BU, please complete the Employee Health Insurance Responsibility Disclosure Form (HIRD), indicating where you do have coverage. The form is available from the Benefits Section at [www.bu.edu/hr](http://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

- 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 Coverage (pre-tax)

- BCBS PPO   
  BCBS Network Blue New England\*   
  Boston Medical Center (BMC) Preferred\*   
  No coverage  
 Type of Coverage:  
  Employee only  
  Employee plus child(ren)  
  Employee plus spouse  
  Family

\*Indicate your primary care physician below.

### 3. Dental Health Plan (pre-tax)

- BU Dental Health Center Plan   
  Dental Blue Freedom Plan   
  No coverage  
 Type 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			PCP NAME AND LOCATION*
				HEALTH	DENTAL	
EMPLOYEE						
SPOUSE						
CHILD						
CHILD						
CHILD						

\* NETWORK BLUE NEW ENGLAND AND BMC PREFERRED

### 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 nineteen:

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 ten times your annual salary. Your family is covered in proportion to the amount of coverage you select.

**8. Reimbursement 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 (cannot exceed \$3,000) until December 31. I would like these contributions to be deducted from my pay over\_\_\_\_\_consecutive pay periods during the calendar year.

Dependent Care Account:

I elect to contribute \$\_\_\_\_\_ in total to my dependent care account (cannot exceed \$5,000) until December 31. I would like these contributions to be deducted from my pay over\_\_\_\_\_consecutive pay periods during the calendar year.

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. 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 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 Handbook. If I have enrolled in a health care or dependent care reimbursement 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 Health Plan subscriber agreement.

SIGNATURE

DATE

**Please return this enrollment form to BU Human Resources, 25 Buick Street, Boston, MA 02215**

FOR BENEFITS OFFICE USE ONLY			
REP. STATUS	PERCENT	DOH	DOP
DUR	LEVEL	DTR	INIT

## Health Care and/or Dependent Care Reimbursement Account Agreement

The following agreements apply if I have enrolled in a health care and/or a dependent care reimbursement 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.