

Flexible Spending Account (Minimum Annual Enrollment \$100.00)

- Medical FSA Annual Pledge: \$ _____
- Dependent Care FSA Annual Pledge: \$ _____
- Decline

Supplemental Term Life Insurance

- 1x Annual Salary 5x Annual Salary
- 2x Annual Salary 6x Annual Salary
- 3x Annual Salary 7x Annual Salary
- 4x Annual Salary Decline

Assign Beneficiaries for the following Plans: (please print clearly)

Basic Life Insurance Beneficiary	Type	%	Relationship	Date of Birth	Address	Phone Number
	Primary					
	Primary					
	Contingent					
	Contingent					
Supplemental Insurance Beneficiary	Type	%	Relationship	Date of Birth	Address	Phone Number
	Primary					
	Primary					
	Contingent					
	Contingent					
Pension Beneficiary	Type	%	Relationship	Date of Birth	Address	Phone Number
	Primary					
	Primary					
	Contingent					
	Contingent					

Aflac Cancer \$10,000 \$20,000 \$30,000 \$40,000 \$50,000

Basic Cancer Plan

- Employee Only Employee & Spouse/Domestic Partner
- Employee & Child(ren) Employee & Family Decline

Aflac Cancer

\$10,000 \$20,000 \$30,000 \$40,000 \$50,000

Enhanced Cancer Plan

- Employee Only Employee & Spouse/Domestic Partner
- Employee & Child(ren) Employee & Family Decline

I certify that I am, and each of my enrolled dependents is, eligible to participate in plans elected for us on this form, as eligibility is defined in each plan. I understand that my benefit elections cannot be changed or revoked before the next open enrollment, unless there is an appropriate status change (such as change in legal marital status, number of dependents, employment status, dependent eligibility, change of residence, or COBRA) or other permitted event such as court order, HIPPA enrollment rights, Medicare/Medicaid eligibility, or significant cost or coverage change. Changes must be requested and documented within 31 days of the event.

AUTHORIZATION: I hereby authorize my licensed physician, hospital, pharmacy, clinic, health care facility, insurance company, employer, or organization to release to University Health or its agents any information regarding me or my enrolled family members' medical history, treatment, and/or disability that is reasonably necessary for the purpose of utilization review, coordination of benefits, or payment of a claim. The authorization shall cease to be effective at such time when my coverage under the plan terminates. In the event that I have any outstanding claims at time of termination, the authorization will continue to apply until all the claims have been settled. I understand that University Health will automatically deduct from my wages the amount of any co-pays I or my dependents incur as a result of receiving medical services or supplies from University Health or any sponsored group health plan, and I give my authorization for such deductions. In addition, in the case of coverage I have elected under any plan indicated with above, I authorize payment of the applicable premiums by means of payroll deduction on a pre-tax basis. For all other plans, I authorize payment of the applicable premiums by means of payroll deduction on an after-tax basis. I hereby attest that the statements made by me are true, and I understand that any material misstatements may be used to contest the validity of my benefits. Proof of dependent status must be submitted for dependents in order to maintain coverage.

Employee Signature:

Date:

Office Use Only:

Date Received:

Initials:

Date Keyed: