HealthCare Insurance Enrollment/Change Form

New Employees: Complete and submit the form no later than thirty (30) calendar day from the first day of employment.

Employees Experiencing a Qualifying Event: For changes due to a qualifying event, this form must be complete and submitted no later than thirty (30) days from the date of the qualifying event. In addition, you must provide proof of the qualifying event which must include the effective date or last day of previous coverage.

EMPLOYEE DEMOGRAPHICS:

LAST, FIRST, MI: _____ **Baner ID:** _____

Change in Status/Qualifying Event – Supporting Documentation is Required: DATE OF QUALIFYING EVENT: _____

☐ Marriage ☐ New Hire ☐ Birth/Adoption ☐ Gain of Coverage ☐ Loss of Coverage ☐ Divorce

☐ Death ☐ Open Enrollment ☐ Change in Dependent Status ☐ Other: _____

ELECTION OF COVERAGE

Medical ☐ PPO ☐ Consumer Driven Health Plan (CDHP) ☐ Employee ☐ Employee+1 ☐ Family ☐ Decline

Dental ☐ Delta Dental ☐ Employee ☐ Employee+1 ☐ Family ☐ Decline

Vision ☐ NVA ☐ Employee ☐ Employee+1 ☐ Family ☐ Decline

Flexible Spending Account (FSA only available with enrollment in the PPO plan) ☐ FSA ☐ Decline

Health Savings Account (HSA only available with enrollment in the CDHP medical plan) ☐ HSA ☐ Decline

Spouse/Children Info	Last, First, MI	Date of Birth	Social Security Number	Gender	Add/Drop	Medical	Dental	Vision

*Eligible dependents are children up to age 26. Is any child over the age limit applying for coverage due to a disability? ☐ Yes ☐ No

AUTHORIZATION

I have read all the statements contained in this application and declare by signing this application that I am an active, eligible, compensated, benefit-eligible employee of Youngstown State University and that the information provided is true and complete to the best of my knowledge. I authorize the university to deduct from my pay, on a pre-tax or after-tax basis, as the applicable employee contributions described in the benefit plan rates online at ysu.edu/employee-benefits. I understand that this authorization to deduct employee contributions (directly from my pay) will remain in effect during the period of coverage and is not revocable, except as described in the applicable plan. I understand and agree that in the event my university pay is not sufficient to pay the employee contributions for the benefits that I elect, or if I go on an unpaid leave of absence, I will be billed directly for these employee contributions. In such case, I agree to pay those employee contributions promptly and in full. I understand that, if employee contributions are not paid in full, the benefits will be terminated for lack of payment, and I will be responsible for employee contributions missed prior to my coverage termination date. I certify that all information provided on this form is true and correct to the best of my knowledge.

If I am electing to decline coverage, I acknowledge that the available coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any.

Signature: _____ Date: _____