ELON UNIVERSITY

Life Status Change Form

Personal Information

Name (Last, First, Middle Initial) ______

Address ______ City ______ State ______ Zip ______

Date of Birth ______ SSN: XXX - XX- ______ Is this a name change? ☐ Y ☐ N Is this an address change? ☐ Y ☐ N

Elon ID ______ Date of Hire ______ Pay Period: ☐ Monthly ☐ Hourly - PP ☐ Hourly - OP

Department ______ Phone Number ______ Email ______

Medical Plan Enrollment/Change

Effective Date: ______

- ☐ New Coverage
- ☐ Change of Existing Coverage
- ☐ Cancel Coverage
- ☐ Waive Coverage
- ☐ No Change to Coverage

Select coverage ***(choose one)***

Choose Type:
- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Domestic Partner
- ☐ Employee & Child(ren)
- ☐ Employee & Family

Choose Coverage:
- ☐ Plan A
- ☐ Plan B
- ☐ Plan C

HSA Contribution - Plan C Only:

Employee Additional Annual Contribution Amount: $__________

Other Medical Insurance? ☐ Y ☐ N

Dental Plan Enrollment/Change

Effective Date: ______

- ☐ New Coverage
- ☐ Change of Existing Coverage
- ☐ Cancel Coverage
- ☐ Waive Coverage
- ☐ No Change to Coverage

Select coverage ***(choose one)***

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

Vision Plan Enrollment/Change

Effective Date: ______

- ☐ New Coverage
- ☐ Change of Existing Coverage
- ☐ No Change to Coverage
- ☐ Cancel Coverage

Select coverage ***(choose one)***

Elon Pays:
- ☐ Employee Only (Basic)
- ☐ Employee & Child(ren) (Basic)
- ☐ Emp. & Spouse/Dom. Partner (Basic)
- ☐ Employee & Family (Basic)

Employee Pays:
- ☐ Employee Only (Buy-up)
- ☐ Employee & Child(ren) (Buy-up)
- ☐ Emp. & Spouse/Dom. Partner (Buy-up)
- ☐ Employee & Family (Buy-up)

Family Member Information

Name: Last, First, Middle Initial	SSN: Last 4#	Relationship	Date of Birth	Gender	Medical	Dental	Vision
	XXX-XX-				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	XXX-XX-				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	XXX-XX-				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	XXX-XX-				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	XXX-XX-				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	XXX-XX-				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Revised 09/30/19

Flexible Spending Account Enrollment (FSA)

Effective Date: _____

Flexible Spending Accounts must be re-elected every year. If you do not submit this form or enroll online, your FSA account will be canceled.

*Health Care FSA annual limit = $2,750
*Dependent Care FSA annual limit = $5,000

☐ Health Care Annual Amount

☐ Dependent Care Annual Amount

Supplemental Insurance

Faculty and Staff have 30 days from date of hire to enroll in the AFLAC plans. To find additional information, please visit http://www.elon.edu/e-web/bft/hr/supInsurance.xhtml.

☐ I am interested and will inquire online. ☐ I am not interested at this time. ☐ I would like to cancel my plan.

Qualifying Event Change

Faculty and Staff have 30 days from the qualifying event to add or remove dependents from coverage. Supporting documentation is required. If your are dropping a dependent, any potential reimbursement will be forfeited if submitted after 30 days from the event.

Date of the Event _____ Effective Date _____

Reason for completing form

☐ New Hire ☐ Marriage ☐ Divorce/Legal Separation ☐ Birth/Adoption of Child ☐ Ineligible Dependent ☐ Emp/Spouse Employment/Benefit Change

☐ Qualifying Partner ☐ Other (Explain): _____

Pre-Tax Premium Plan

By signing below, I elect to have premiums for my medical, dental, vision, flex spending account(s) and Supplemental Insurance Coverage-AFLAC deducted from my pay on a pre-tax basis. Premiums will be deducted from my regular compensation on a pre-tax basis and will continue unless I elect otherwise. I understand that this election cannot be modified or terminated unless there is a change in family status or spouse's employment.

Important Information, please read before signing:

I request the coverages for myself and any eligible dependents as listed on this form and authorize my employer to deduct from my pay my contribution (if any) for the cost of the coverages.

I agree to be bound by all terms of the plans under which I am applying for coverage. I agree that a copy of this authorization shall be valid as the original. I certify that, to the best of my knowledge, the information shown on this enrollment form is correct and that will notify the University promptly of any changes in the information contained in this application.

Signature of Employee: _____ **Date:** _____

EAP - FREE **LIFE - FREE Eff. Date:** _____ **DEPENDENT LIFE - $7,500 (A)** _____ **$15,000 (B)** _____

OPTIONAL LIFE - OPEM _____ **OPSP** _____ **OPCH** _____

LTD: SLTD (100% MS) ___ **MLTD (Shared)** ___ **BLTD (100% BH/BI)** ___ HR use only

AFLAC ELECTIVE INSURANCE - GROUP $ _____ **ELECTIVE $** _____

FLEX SPENDING PP AMT - Medical: _____ **Dependent care:** _____

PLAN C - ADD ELON'S PORTION OF $500 (JAN - JUNE) _____ **OR $250 (JULY - DECEMBER)** _____

PLAN C FAMILY - ADD ELON'S PORTION OF $1000 (JAN - JUNE) _____ **OR $500 (JULY - DECEMBER)** _____

PLAN C EMPLOYEE CONTRIBUTION PAY PERIOD AMT: _____

RETIREMENT - MRTR- TIAA Mand. 4%-8% Match _____ **Eligible for Catch-up (50+ YR): Yes** ____ **No** ____

SRA% _____ **MSRA** _____ **ROTH** _____ **RTH%** _____ **Eligible for Catch-up (50+ YR): Yes** ____ **No** _____

HR Signature: _____ **Date:** _____

Payroll received: _____ **Date:** _____

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