2008 GENERIC OPEN ENROLLMENT FORM

PART-TIME EMPLOYEE

Due Wednesday April 30, 2008
Changes/Enrollment Effective July 1, 2008

Name: ______________________

UNID: ______________________

PLEASE NOTE: The rates provided below are monthly and include dental coverage.

1. Visit the online enrollment or,
2. Complete this form
3. If you do not want to change your health plan election or coverage level you **DO NOT** need to complete this form.
4. See reverse side for more information

You Are Currently Enrolled In:	Wellness Program Participation:
	If you participate in the **Wellness Program** you will receive a monthly discount of up to $40. *If your health plan contribution is less than $40 per month your cost of coverage will be zero.*

Network Option	Plan Option	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
University Health Care Plus	Basic	o $234.40	o $407.07	o $556.48
	Comprehensive	o $255.90	o $443.39	o $605.26
	Advantage	o $267.72	o $463.37	o $632.07

Network Option	Plan Option	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
ValueCare	Basic	o $240.12	o $416.71	o $569.44
	Comprehensive	o $261.62	o $453.03	o $618.22
	Advantage	o $273.44	o $473.01	o $645.03

Network Option	Plan Option	Employee Only	Employee + 1 Dependent	Employee + 2 or more Dependents
BlueCross BlueShield	Basic	o $255.62	o $442.89	o $604.62
	Comprehensive	o $277.12	o $479.21	o $653.40
	Advantage	o $288.94	o $499.19	o $680.21

O **Waive Dental** (Deduct amount shown from above rates)	-$18.22	-$41.80	-$65.96

O **Cancel Health and Dental Coverage**

ENROLLED DEPENDENTS: Please confirm that each dependent listed below meets the Health Plan's eligibility requirements. The Health Plan defines Eligible Dependents as: (a) the person to whom you are legally married; (b) your (or your spouse's) unmarried children by birth, placement for legal adoption or foster care, or legal (court-appointed) guardianship, who are under age 26 and dependent on you for more than 50% of their support; and (c) eligible children age 26 or older for whom student status or eligible disability has been certified as required by the Plan.

Name	Birth Date	Gender	Relationship	Add / Drop Dependent(s)
				☐ Add ☐ Drop
				☐ Add ☐ Drop
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I have reviewed and understand the Plan rules stated on the back of this election form. I certify that the information I have provided on this form is true and correct. I understand that the changes requested on this form will be effective July 1, 2008. I understand that knowingly providing a statement that contains any false, incomplete or misleading information (including enrollment of an individual who does not meet the Plan's eligibility requirements) may result in adverse employment action, up to and including termination of employment. I authorize the University of Utah to make the requested changes to my benefit election(s) and to deduct the required contributions from my paychecks.

Employee Signature: ______________________ **Date:** __________

Email Address: ______________________ **Daytime Phone**: ______________________

(Contact information for clarification or corrections)

HR Office Use Only: QC by: ________
Entered by:________Date:________

HEALTH PLAN ENROLLMENT

ENROLL/CHANGE/CANCEL: If you wish to enroll, change or cancel your health coverage, you have two options:

- Enroll online between April 7th - 30th. Go to **https://gate.acs.utah.edu**. Log on and click on the "Employee" tab then click on the "Open Enrollment 2008" Link; **OR**
- Complete this form, sign, and submit it to the University Benefits Department on or before April 30, 2008. You may submit the form in person, via mail, or by fax.

Submit your completed form to:

- Benefits Department - 420 Wakara Way Ste. 105, SLC, UT 84108
- University Hospital Employee Service Center A-024
- 135 Park Building

OR Fax to: Benefits Department - (801) 585-7375

To participate in the Flexible Spending Accounts for the 2008 Plan Year you must enroll online or return the Flexible Spending Account (FSA) Enrollment Form enclosed in your Open Enrollment packet.

If you do not wish to use the online enrollment feature and wish to enroll in coverage, cancel coverage, add or drop dependents, or change your Network or Plan Option(s) complete and return this form.
Please keep a copy of your completed form for your records.

Medical and Dental Coverage Information

- I hereby make application on behalf of myself and listed eligible family dependents for enrollment in the University of Utah Employee Health Care Plan as indicated hereon.
- I understand that participation in the University Health Care Plan is a prerequisite for enrollment in dental coverage.
- I understand that I may not change or cancel these elections during the plan year, unless I experience a status change event change that would be consistent with my requested change and otherwise meets IRS criteria governing valid election changes. All plan election changes must be submitted within 3 months of the status change event date. Otherwise, I will forfeit any right to make this change until the next Annual Open Enrollment.
- I understand that contributions for my Health Care Plan elections made on this form will begin on my July 22, 2008 paycheck. I understand that deductions for Flexible Spending, if elected, will begin on my July 7, 2008 paycheck.
- To the extent allowed under federal law, I understand the Health Care Plan does not cover treatment of pre-existing conditions for new members during the first 6 months following timely enrollment or during the first 18 months following enrollment for late enrollees unless the pre-existing condition waiting period is reduced by prior creditable coverage as defined by HIPAA. I am responsible for submitting a certificate(s) or other evidence of prior creditable coverage.
- To the minimum extent necessary to implement coverage, and in accordance with rules set forth in the HIPAA Privacy Regulations, I authorize Regence BlueCross BlueShield of Utah, University Health Care Plus, Behavioral Health Strategies, Caremark, and ASI Flex to request any medical, health, employment, and/or insurance information necessary to complete my enrollment and process my claims.
- I authorize payroll deduction of contributions as required through the provisions of IRC Section 125 Flexible Benefits. I agree to abide by the Plan's enrollment provisions. I authorize my employer to act as my agent in all matters of administration of the group program and acknowledge that my employer is in no way acting as agent for those companies administering claims.
- I certify that all information on this form is true and correct and I acknowledge that the University will take corrective action against Participants who (a) enroll an individual in the Health Care Plan that they know or should know is ineligible and/or (b) file claims (either directly or indirectly through a health care provider) for an individual that they know or should know is ineligible for coverage under the Plan. Corrective action includes termination of employment, legal action for reimbursement of all claims, and cancellation of coverage without the right to elect COBRA continuation coverage.
- I understand that the University intends to continue the Plan indefinitely; however, it reserves the right to amend, suspend or discontinue it at any time.