



NORTHWESTERN
UNIVERSITY

Benefits Enrollment and Change Form

| | | |
|--|---|--|
| STATUS: <input type="checkbox"/> Active Employee <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Newly Eligible | ACTION: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Adding Dependents <input type="checkbox"/> Dropping Dependents <input type="checkbox"/> Changing Life or AD&D Insurance <input type="checkbox"/> Changing Beneficiaries NOTE: Employees must submit a completed form within 31 days from the date of the qualifying change in family status. Otherwise, certain plans require evidence of good health. | QUALIFYING CHANGE IN FAMILY STATUS <input type="checkbox"/> Marriage <input type="checkbox"/> Birth, Adoption <input type="checkbox"/> Loss of Spouse Coverage <input type="checkbox"/> Divorce <input type="checkbox"/> Other DATE OF QUALIFYING CHANGE ____ / ____ / ____ |
|--|---|--|

1. PERSONAL INFORMATION

| | | | | |
|--|--------------------------------------|------------------------------|---|--|
| Last Name | First Name | M.I. | SOCIAL SECURITY # ____ - ____ - ____ | SEX <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Street Address | | Apt. | City | State |
| Zip | DATE OF BIRTH: ____ / ____ / ____ | | DATE OF HIRE: ____ / ____ / ____ | E-MAIL ADDRESS |
| HOME PHONE: (____) ____ - ____ | | CAMPUS PHONE: ____ - ____ | | |
| MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced | | | | |

2. HEALTH PLAN SELECTION

| | |
|---|--|
| I ELECT TO: <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> change HEALTH INSURANCE COVERAGE <input type="checkbox"/> PLAN A (Blue Cross & Blue Shield PPO Plus Plan) <input type="checkbox"/> Aetna HMO Plan <input type="checkbox"/> Unicare HMO Plan <input type="checkbox"/> Humana HMO Plan <input type="checkbox"/> HMO Illinois (A Blue Cross HMO) | If you are selecting an HMO, please refer to the plan brochure and indicate the Participating Medical Group and Group Number (if applicable). If you select an HMO, please designate a primary care physician for yourself and each family member. Health Center or Physician Group (IPA) Name: <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage IPA or Site Number Primary Care Physician |
| Office <input type="checkbox"/> Entered into HRIS Use Only: <input type="checkbox"/> Submitted to Provider | Coverage Effective Date Group and Section Number |

3. DENTAL SELECTION

| | |
|--|---|
| I ELECT TO: <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> change DENTAL INSURANCE COVERAGE <input type="checkbox"/> First Commonwealth DHMO Plan 3000A <input type="checkbox"/> Blue Cross & Blue Shield PreDent - Indemnity Plan | If you are selecting First Commonwealth, please refer to the plan brochure and indicate the Participating 6-digit DHMO dental location number. <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage DMO Dental Location Code: |
| Office <input type="checkbox"/> Entered into HRIS Use Only: <input type="checkbox"/> Submitted to Provider | <input type="checkbox"/> Pending EOI <input type="checkbox"/> EOI Approval Coverage Effective Date Group and Section Number |

4. OTHER INSURANCE INFORMATION

Do you or any of your family members have other Group Health or Dental Insurance? Yes No If yes, please complete the following:

| | | |
|---|--|--|
| NAME OF INSURED: | EMPLOYER: | POLICY NUMBER: |
| INSURANCE COMPANY NAME: | INSURANCE COMPANY ADDRESS: | |
| Are you covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO | Is your spouse? <input type="checkbox"/> YES <input type="checkbox"/> NO | If over 65: <input type="checkbox"/> Presently employed <input type="checkbox"/> Retired |

5. DEPENDENT INFORMATION

| Relationship | Date of Birth | Name (Last [if different], First MI) | Social Security # | HMO Primary Physician And Site Number | Add/Drop | Health/Dental |
|--|--------------------|---|--------------------|---------------------------------------|---|--|
| Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female | ____ / ____ / ____ | | ____ - ____ - ____ | | <input type="checkbox"/> Add <input type="checkbox"/> Drop | <input type="checkbox"/> Health <input type="checkbox"/> Dental |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | ____ / ____ / ____ | | ____ - ____ - ____ | | <input type="checkbox"/> Add <input type="checkbox"/> Drop | <input type="checkbox"/> Health <input type="checkbox"/> Dental |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | ____ / ____ / ____ | | ____ - ____ - ____ | | <input type="checkbox"/> Add <input type="checkbox"/> Drop | <input type="checkbox"/> Health <input type="checkbox"/> Dental |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | ____ / ____ / ____ | | ____ - ____ - ____ | | <input type="checkbox"/> Add <input type="checkbox"/> Drop | <input type="checkbox"/> Health <input type="checkbox"/> Dental |

Signature _____

Date _____



**Benefits Change Form
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Submit completed form to

**Benefits Division
720 University Place
Evanston, IL 60208**

PERSONAL INFORMATION

| | | | | |
|------|-------|------|--|---|
| Last | First | M.I. | Social Security # ____ - ____ - _____ | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
|------|-------|------|--|---|

5. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

| | | | | |
|--|--|--|---------------------------------|---|
| I ELECT TO: <input type="checkbox"/> Enroll in the A D & D Plan <input type="checkbox"/> Waive A D & D Plan Coverage | <ul style="list-style-type: none"> • Available to Faculty and Staff • Choice of Single or Family Coverage • Choice of coverage in \$10,000 increments to \$1 million maximum • Individuals may enroll at anytime | Choose Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family | Coverage Amount \$ _____ | Office Use Only Effective Date: <input type="checkbox"/> HRIS Entry |
|--|--|--|---------------------------------|---|

6. SHORT TERM DISABILITY (STD) PLAN (ENROLLMENT MAY REQUIRE EVIDENCE OF GOOD HEALTH)

| | | |
|--|---|---|
| I ELECT TO: <input type="checkbox"/> Enroll in the STD Plan <input type="checkbox"/> Waive STD Plan Coverage | <ul style="list-style-type: none"> • Available to Staff only. Faculty should refer to the Faculty Handbook for sick leave policies • Requires one year of benefits eligible University service • Provides financial protection from loss of income due to disability • Plan pays 60% of pre-disability income • No premium deductions are taken during the one year waiting period • Benefits are provided after 14 days of disability up to 6 months • A completed enrollment form must be submitted within 31 days from the date of hire or benefits eligibility. • Eligible individuals may apply for STD coverage after 31 days from the date of hire or benefits eligibility by submitting an enrollment form and evidence of good health application. Coverage after 31 days is subject to the approval of the sponsoring insurance company. | Office Use Only Effective Date: <input type="checkbox"/> HRIS Entry |
|--|---|---|

7. LONG TERM DISABILITY (LTD) PLAN (ENROLLMENT MAY REQUIRE EVIDENCE OF GOOD HEALTH)

| | | |
|--|---|---|
| I ELECT TO: <input type="checkbox"/> Enroll in LTD Plan <input type="checkbox"/> Waive LTD Plan Coverage | <ul style="list-style-type: none"> • Available to Faculty and Staff. • Provides financial protection from loss of income due to disability • Benefits are provided after 6 months of disability • Plan pays 60% of pre-disability income • Requires one year of University service and attainment of age 24. • A completed enrollment form must be submitted within 31 days from the date of hire or benefits eligibility. Eligible individuals may apply for LTD coverage after 31 days from the date of hire or benefits eligibility by submitting an enrollment form and evidence of good health application. Coverage after 31 days is subject to the approval of the sponsoring insurance company. | Office Use Only Effective Date: <input type="checkbox"/> HRIS Entry |
|--|---|---|

8. LONG TERM CARE, FLEXIBLE SPENDING ACCOUNT AND RETIREMENT PLANS - Use Separate Forms

| | | |
|--|---|--|
| <p align="center">LONG TERM CARE</p> <ul style="list-style-type: none"> • Available to Faculty and Staff • Provides some degree of financial protection from the costs of services for individuals who are unable to care for themselves • Eligible individuals must submit completed enrollment form within 31 days of benefits eligible employment • Choice of three daily benefit options and two inflation protection features • Separate enrollment form in benefits packet | <p align="center">FLEXIBLE SPENDING ACCOUNTS</p> <ul style="list-style-type: none"> • Available to Faculty and Staff • Tax savings plan for out-of-pocket health, dental, prescription and child care expenses • Eligible Individuals must submit completed enrollment form within 31 days from the date of benefits eligible employment • Separate enrollment form in benefits packet | <p align="center">RETIREMENT PLAN</p> <ul style="list-style-type: none"> • Available to Faculty and Staff • Provides the opportunity to accumulate a source of retirement income in addition to Social Security and personal savings • Requires 1 year of University benefits eligible service and attainment of age 24. Service requirement may be waived, see waiver information in benefits packet • Requires submittal of completed enrollment form and investment company application(s) • Separate enrollment forms in benefits packet |
|--|---|--|



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Evanston, IL 60208**

PERSONAL INFORMATION

| | | | | |
|------|-------|------|--|---|
| Last | First | M.I. | Social Security # ____ - ____ - _____ | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
|------|-------|------|--|---|

9. TERM LIFE INSURANCE PLANS

| | | | |
|--|---|--|-----------------|
| <p>EMPLOYEE GROUP TERM LIFE INSURANCE PLAN: Coverage is provided by the University at its cost equal to 2.5 times an individual's University salary up to maximum coverage of \$200,000. The coverage factor reduces by 8% each year beginning at age 55. Cost of coverage above \$50,000 is subject to IRS imputed income tax and is added to taxable wages.</p> <p><input type="checkbox"/> I ELECT TO REDUCE my Group Term Life Insurance coverage to \$50,000. I understand this level of coverage is not subject to imputed income tax and that should I wish to increase Group Term Life Insurance coverage to my eligible level at a later date, I must submit and have approved an Evidence of Good Health (EOI) application.</p> | | | Office Use Only |
| <p>EMPLOYEE OPTIONAL TERM LIFE INSURANCE COVERAGE</p> <p>I ELECT TO:</p> <p><input type="checkbox"/> Enroll in Optional Term Life Insurance Plan</p> <p><input type="checkbox"/> Waive Optional Term Life Insurance Coverage</p> | <p>Please specify coverage amount and attach a completed Aetna Evidence of Good Health Application if electing 3, 4, or 5 times coverage.</p> <p><input type="checkbox"/> 1 Times Annual Salary <input type="checkbox"/> 4 Times Annual Salary <input type="checkbox"/> 2 Times Annual Salary <input type="checkbox"/> 5 Times Annual Salary <input type="checkbox"/> 3 Times Annual Salary</p> | <p>Effective Date :</p> <p><input type="checkbox"/> HRIS Entry</p> | |

| | | | |
|--|---|--|-----------------|
| <p>SPOUSE TERM LIFE INSURANCE COVERAGE</p> <p>I ELECT TO:</p> <p><input type="checkbox"/> Enroll in Spouse Life Insurance Plan</p> <p><input type="checkbox"/> Waive Spouse Life Insurance Coverage</p> | | | Office Use Only |
| <p><input type="checkbox"/> Enroll in Spouse Life Insurance Plan</p> <p><input type="checkbox"/> Waive Spouse Life Insurance Coverage</p> | <ul style="list-style-type: none"> Available to Faculty and Staff if enrolled in Optional Term Life Insurance Plan Coverage is available in \$10,000 increments to maximum of \$250,000 not to exceed 50% of employee's Optional Life coverage. Coverage above \$30,000 requires evidence of good health May enroll within 31 days of benefits eligible employment. Coverage after 31 days is subject to approval of sponsoring insurance company | <p>Please Specify Coverage Amount</p> <p>_____</p> <p>Effective Date:</p> <p><input type="checkbox"/> HRIS Entry</p> | |

| | | | |
|--|---|--|-----------------|
| <p>DEPENDENT CHILD(REN) TERM LIFE INSURANCE COVERAGE</p> <p>I ELECT TO:</p> <p><input type="checkbox"/> Enroll in Dependent Child Life Insurance Plan</p> <p><input type="checkbox"/> Waive Dependent Child Life Insurance Coverage</p> | | | Office Use Only |
| <p><input type="checkbox"/> Enroll in Dependent Child Life Insurance Plan</p> <p><input type="checkbox"/> Waive Dependent Child Life Insurance Coverage</p> | <ul style="list-style-type: none"> Available to Faculty and Staff if enrolled in Optional Term Life Insurance Plan Coverage is available in \$2,000 increments to maximum of \$10,000. Amount specified will apply to each dependent child listed below May enroll within 31 days of benefits eligible employment Coverage after 31 days is subject to approval of sponsoring insurance company | <p>Please Specify Coverage Amount</p> <p>_____</p> <p>Effective Date:</p> <p><input type="checkbox"/> HRIS Entry</p> | |

SPOUSE AND DEPENDENT CHILD INFORMATION

| Relationship | Name (Last Name [if different], First Name, MI) | Date of Birth | Social Security # |
|---|--|---------------|---------------------|
| <input type="checkbox"/> Spouse <input type="checkbox"/> Male <input type="checkbox"/> Female | | ___/___/___ | ____ - ____ - _____ |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | ___/___/___ | ____ - ____ - _____ |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | ___/___/___ | ____ - ____ - _____ |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | ___/___/___ | ____ - ____ - _____ |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | ___/___/___ | ____ - ____ - _____ |

Please Specify Beneficiary Designations on Next Page



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| | | | | |
|------|-------|------|--|---|
| Last | First | M.I. | Social Security # _____ - _____ - _____ | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
|------|-------|------|--|---|

BENEFICIARY DESIGNATIONS Please specify a beneficiary(s), note the applicable insurance plan(s) and the relationship of the beneficiary(s) to you. Beneficiaries for the A D & D Plan will follow the beneficiary designations for the Group Term Life Insurance Plan.

| | | | | |
|------------------------------------|--------------|---------------|--|---|
| Beneficiary 1: (Last, First MI) | | Relationship: | <input type="checkbox"/> Group Life <input type="checkbox"/> Optional Life <input type="checkbox"/> Spouse Life <input type="checkbox"/> Dependent Child Life | <input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary |
| Home Phone (____) _____ - _____ | Street & Apt | City | State | Zip |
| Beneficiary 2: (Last, First MI) | | Relationship: | <input type="checkbox"/> Group Life <input type="checkbox"/> Optional Life <input type="checkbox"/> Spouse Life <input type="checkbox"/> Dependent Child Life | <input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary |
| Home Phone (____) _____ - _____ | Street & Apt | City | State | Zip |
| Beneficiary 3: (Last, First MI) | | Relationship: | <input type="checkbox"/> Group Life <input type="checkbox"/> Optional Life <input type="checkbox"/> Spouse Life <input type="checkbox"/> Dependent Child Life | <input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary |
| Home Phone (____) _____ - _____ | Street & Apt | City | State | Zip |
| Beneficiary 4: (Last, First MI) | | Relationship: | <input type="checkbox"/> Group Life <input type="checkbox"/> Optional Life <input type="checkbox"/> Spouse Life <input type="checkbox"/> Dependent Child Life | <input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary |
| Home Phone (____) _____ - _____ | Street & Apt | City | State | Zip |
| Beneficiary 5: (Last, First MI) | | Relationship: | <input type="checkbox"/> Group Life <input type="checkbox"/> Optional Life <input type="checkbox"/> Spouse Life <input type="checkbox"/> Dependent Child Life | <input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary |
| Home Phone (____) _____ - _____ | Street & Apt | City | State | Zip |
| Beneficiary 6: (Last, First MI) | | Relationship: | <input type="checkbox"/> Group Life <input type="checkbox"/> Optional Life <input type="checkbox"/> Spouse Life <input type="checkbox"/> Dependent Child Life | <input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary |
| Home Phone (____) _____ - _____ | Street & Apt | City | State | Zip |

AUTHORIZATION

(1) I elect coverage under the above-selected benefit plan(s) on behalf of myself and the above listed dependents and I authorize any payroll deductions required. (2) I certify that the above information is correct to the best of my knowledge and belief. (3) I authorize any licensed physician, medical practitioner, hospital, clinic, government agency or other health or medically-related facility, insurance company, organization or institution that has any records or knowledge of my health and that of my dependents to exchange such information with the selected provider--including, without limitations, information relating to mental illness or use of drugs or alcohol. I understand that the information will be used for the purpose of review, investigation, or evaluation of my application for coverage and claims for benefits provided to me and or my dependents. (4) I agree to abide by the terms and conditions of the Plan Document and Certificates of Insurance. This authorization is valid for the term of coverage of the contract under which this enrollment is effective. I am aware of my right to receive a copy of the authorization upon request and agree that a photographic copy of this authorization is as valid as the original. **(5) I agree that this enrollment form and applicable evidence of good health application will not be processed until I have completed such form(s) in full, and have provided responses to questions about my request for participation in all plans listed on this form.**

SIGNATURE

DATE