



2009 Qatar Benefits Enrollment Form

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**Submit completed form to
Benefits Division
720 University Place
Evanston, IL 60208**

ACTION: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Adding Dependents <input type="checkbox"/> Dropping Dependents <input type="checkbox"/> Other Benefit Changes	QUALIFYING CHANGE <input type="checkbox"/> Transfer to Qatar <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Change Eligibility of Other Coverage <input type="checkbox"/> Other _____
NOTE: Employees must submit a completed form and required documentation within 31 days of the qualifying change in family or employment status.	
DATE OF QUALIFYING CHANGE ____ / ____ / ____	

PERSONAL INFORMATION		Social Security Number (Needed by Health/Dental/Vision Vendors)	Employee ID (On Your NU Wildcard)
		_____ - _____ - _____	_____ - _____
Last Name	First Name	M.I.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Home Street Address		Apt	City
		State	Zip
Date of Birth	Date of Hire	Home Phone	Work Phone
____/____/____	____/____/____	() -	() -
		Email	

1. DEPENDENT INFORMATION (Please list dependents you wish covered under the health, dental or vision plans with their SSN if available. If the SSN is not available, due to a recent birth, you still must submit a completed enrollment form within 31 days from qualifying change in status.)

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

2. OTHER INSURANCE INFORMATION

Do you or any of your family members have other Group Health or Dental Insurance? If yes, please complete the remainder of this section. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your spouse covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you are over 65 are you: <input type="checkbox"/> presently employed <input type="checkbox"/> retired
Name of Insured:	Employer:	Policy Number:	
Insurance Company:	Insurance Company Address:		

SIGNATURE	DATE
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3. HEALTH INSURANCE PLAN (If no election is made, your election will be recorded as waived)

I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive* <input type="checkbox"/> no change	Choose Your Health Plan <input type="checkbox"/> CIGNA International Expatriates Benefits (CIEB) Plan	Choose Your Coverage <input type="checkbox"/> You <input type="checkbox"/> You + spouse <input type="checkbox"/> You + child(ren) <input type="checkbox"/> You + spouse +child(ren)
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* If I chose to waive health care coverage, I acknowledge that Northwestern University offers employer sponsored health care plan coverage and requires all benefits eligible faculty and staff to elect or waive such coverage. I do not wish University sponsored coverage. I acknowledge my full responsibility for medical/hospitalization and outpatient expenses of any kind when incurred and release and discharge Northwestern University, its employees and agents from any obligations I may incur as a result of an illness or injury.

Signature		Date
Office Use Only:	<input type="checkbox"/> Entered into HRIS <input type="checkbox"/> Submitted to Provider Group and Section Number:	Effective Date:

4. DENTAL INSURANCE PLAN (If no election is made, your election will be recorded as waived)

I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> no change	Choose Your Dental Plan <input type="checkbox"/> CIGNA International Expatriates Benefits (CIEB) Plan	Choose Your Coverage <input type="checkbox"/> You <input type="checkbox"/> You +spouse <input type="checkbox"/> You + child(ren) <input type="checkbox"/> You + spouse + child(ren)
Office Use Only:	<input type="checkbox"/> Entered into HRIS <input type="checkbox"/> Submitted to Provider Group and Section Number:	Effective Date:

5. VISION INSURANCE PLAN (If no election is made, your election will be recorded as waived)

I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> no change	<input type="checkbox"/> CIGNA International Expatriates Benefits (CIEB) Plan	Choose Your Coverage <input type="checkbox"/> You <input type="checkbox"/> You + spouse <input type="checkbox"/> You + child(ren) <input type="checkbox"/> You + spouse + child(ren)
Office Use Only:	<input type="checkbox"/> Entered into HRIS <input type="checkbox"/> Submitted to Provider	Effective Date:

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Once an individual has enrolled in an FSA, the annual pledge amount may not be changed unless there is a qualifying change in family or employment status and the individual completes the enrollment process within 31 days from the date of the event. This election is effective until December 31, 2009 or until a qualifying change in status.

Last Name	First Name	M.I.	Employee ID # ____ _
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6. Health Care Account

I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> change amount <input type="checkbox"/> no change	Annual Election Amount \$	<ul style="list-style-type: none"> The maximum monthly contribution amount is the annual election amount divided by the number of months of participation (\$10,000 for 12 months). \$240 is the minimum annual contribution. Any monies remaining in the account as of March 1, 2010 are forfeited.
Office Use Only:	<input type="checkbox"/> Entered into HRIS	Effective Date:

7. Dependent Care Account

<input type="checkbox"/>	I am eligible to receive Dependent Care matching funds from the University. Attach a Dependent Care University Match Application and a copy of your most recent 1040 form filed with the IRS showing your tax filing status and Adjusted Gross Family Income. The maximum matching contribution is the maximum monthly amount times the number of remaining months in the calendar year.
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I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> change amount <input type="checkbox"/> no change	Annual Election Amount \$	<ul style="list-style-type: none"> The maximum annual election amount is \$5,000 if you are single or married filing taxes jointly. If you are married and file taxes separately, the annual maximum annual election amount is \$2,500. \$240 minimum annual contribution. Enrolling in this plan automatically makes you eligible for Back Up Child Care benefits from the University Any monies remaining in the account as of March 1, 2010 are forfeited.
Office Use Only:	<input type="checkbox"/> Entered into HRIS	Effective Date:

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8. TERM LIFE INSURANCE PLANS

Please visit <http://www.northwestern.edu/hr/benefits/plans/life/standardcalc/needs.html> to determine benefit coverage amounts, premiums and imputed income taxes using customized online life insurance calculators.

Beneficiary changes may be made at any time using eBenefits.

EMPLOYEE BASIC TERM LIFE INSURANCE COVERAGE I ELECT TO <input type="checkbox"/> enroll in coverage of 2.5x annual salary <input type="checkbox"/> reduce Basic Term Life Insurance coverage to \$50,000 <input type="checkbox"/> no change	<ul style="list-style-type: none"> Coverage is provided by the University at its cost equal to 2.5 times an individual's University annual salary up to a maximum eligible salary of \$100,000 and maximum coverage of \$250,000. The coverage factor reduces by 8% each year beginning the first of the year an individual turns age 55. The cost of coverage above \$50,000 is subject to IRS imputed income tax and is added to the covered employee's taxable wages. There is no cost to the employee for this coverage. If a coverage amount of \$50,000 is selected, this level of coverage is not subject to imputed income tax. If you should wish to increase Basic Term Life Insurance coverage to my eligible level at a later date, you must submit and have approved an Evidence of Insurability.
Office Use Only:	<input type="checkbox"/> Entered into HRIS Effective Date: _____

EMPLOYEE SUPPLEMENTAL LIFE INSURANCE COVERAGE I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> change amount <input type="checkbox"/> no change	Please specify your desired coverage amount and attach a completed Evidence of Insurability form. <table style="width: 100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> 1 Times Annual Salary</td> <td><input type="checkbox"/> 3 Times Annual Salary</td> </tr> <tr> <td><input type="checkbox"/> 2 Times Annual Salary</td> <td><input type="checkbox"/> 4 Times Annual Salary</td> </tr> <tr> <td></td> <td><input type="checkbox"/> 5 Times Annual Salary</td> </tr> </table>	<input type="checkbox"/> 1 Times Annual Salary	<input type="checkbox"/> 3 Times Annual Salary	<input type="checkbox"/> 2 Times Annual Salary	<input type="checkbox"/> 4 Times Annual Salary		<input type="checkbox"/> 5 Times Annual Salary
<input type="checkbox"/> 1 Times Annual Salary	<input type="checkbox"/> 3 Times Annual Salary						
<input type="checkbox"/> 2 Times Annual Salary	<input type="checkbox"/> 4 Times Annual Salary						
	<input type="checkbox"/> 5 Times Annual Salary						
Office Use Only:	<input type="checkbox"/> Entered into HRIS Effective Date: _____						

SPOUSE TERM LIFE INSURANCE COVERAGE I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> change amount <input type="checkbox"/> no change	<ul style="list-style-type: none"> Available to Faculty and Staff Coverage is available in \$10,000 increments to a maximum coverage of \$500,000 not to exceed 100% of the sum of an employee's Supplemental Life and Basic Life coverage. May enroll within 31 days of marriage with a coverage amount up to \$30,000 without Evidence of Insurability Otherwise, coverage of any amount requires submittal of Evidence of Insurability and approval of the sponsoring insurance company. 	Please Specify Coverage Amount \$ _____
Office Use Only:	<input type="checkbox"/> Entered into HRIS Effective Date: _____	

DEPENDENT CHILD(REN) TERM LIFE INSURANCE COVERAGE I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> change amount <input type="checkbox"/> no change	<ul style="list-style-type: none"> Available to Faculty and Staff Coverage is available in \$2,000 increments to a maximum coverage of \$10,000 per child. Amount specified will automatically apply to all eligible dependent children listed on page 1. May enroll within 31 days of a qualifying event. 	Please Specify Coverage Amount \$ _____
Office Use Only:	<input type="checkbox"/> Entered into HRIS Effective Date: _____	

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9. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> change amount <input type="checkbox"/> no change	<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 not to exceed 10 times your annual University salary 	Choose Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Coverage Amount \$ _____
Office Use Only: <input type="checkbox"/> Entered into HRIS		Effective Date:	

10. SHORT TERM DISABILITY (STD) PLAN

I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> no change	<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 non work related disability • Plan pays 60% of pre-disability income • No premium deductions are taken during the one year waiting period • Benefits are provided after 14 calendar 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. After initial eligibility, individuals may apply for STD coverage by submitting an enrollment form and evidence of good health application within 31 days of a qualifying change in family or employment status or during the annual Open Enrollment period. Coverage after 31 days and through Open Enrollment is subject to the approval of the claims administrator. 	
Office Use Only: <input type="checkbox"/> Entered into HRIS		Effective Date:

11. LONG TERM DISABILITY (LTD) PLAN

I ELECT TO <input type="checkbox"/> enroll in <input type="checkbox"/> waive <input type="checkbox"/> no change	<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 70% of pre-disability income less your social security disability income • Requires one year of University service and attainment of age 24. • No premium deductions will be taken during the one year waiting period. • A completed enrollment form must be submitted within 31 days from the date of hire or benefits eligibility. After initial eligibility, individuals may apply for LTD coverage by submitting an enrollment form and evidence of good health application within 31 days of a qualifying change in family or employment status or during the annual Open Enrollment period. Coverage after 31 days and through Open Enrollment is subject to the approval of the claims administrator. 	
Office Use Only: <input type="checkbox"/> Entered into HRIS		Effective Date:

SIGNATURE	DATE
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