BENEFITS CHANGE FORM

Please fill out the form completely and return to the following address within 31 days of your Change In Status Date:

The University of Chicago Human Resource - Benefits Office
6054 S. Drexel
Chicago, IL 60637

or

Fax: 773-753-3319

(Please Print and use BLACK INK ONLY)

Employee Information

Name:   Last Name, First Name, Middle Initial

Gender
□ Male
□ Female

SS #

Date of Birth

Hire Date

Address

City, State, Zip

Home Phone

Work Phone

Department Name

Work E-Mail

□ Address Change
□ Drop Dependents
□ New Hire
□ Name Change
□ Terminating
□ Adding Dependents
□ Cancel Coverage

Qualified Life Event Changes

□ Birth
□ Adoption
□ Legal Guardianship
□ Marriage/Domestic Partner
□ Divorce
□ Change in job status (Full-Time to Part Time)
□ Loss of Coverage
□ Death

□ Change in job status (Part-Time to Full-Time)

Effective Date:

Select Medical Plan

I want to be covered by the following Medical Plan: (Check one box)

□ Maroon Plan (BCBS IL PPO)
□ HMO Illinois (BCBS IL HMO)
□ University of Chicago Health Plan (UCHP)
□ Illinois Platinum HMO (Humana)
□ I want to waive Medical Coverage (I certify that I currently have other Medical Coverage).

Select the level of Coverage you want below: (Check one box)

□ Yourself
□ Yourself + One Dependent
□ Family

Select Dental Plan

I want to be covered by the following Dental Plan: (Check one box)

□ MetLife Dental Co-Pay Plan
□ MetLife Dental PPO Plan
□ I want to waive dental coverage.

Select the level of Coverage you want below: (Check one box)

□ Yourself
□ Yourself + One Dependent
□ Family

Select Vision Coverage

I want to select the following level of VSP Coverage: (Check one box)

□ Yourself
□ Yourself + One Dependent
□ Family
□ I want to waive vision coverage.
BENEFITS CHANGE FORM

SS# ________________________

Employee/Dependent Coverage
If you enroll in UCHP list the physician or PCG, HMO-IL list the Medical Group Name+ Group I.D. number, Humana list the Physician + I.D. number, each Dependent may select a different contracting Medical Group/Physician.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Name (Last, [if different], First, MI)</th>
<th>Date of Birth MM/DD/YY</th>
<th>SS #</th>
<th>HMO Medical Group Name and I.D. # or Physician’s Name &amp; I.D.#</th>
<th>Medical</th>
<th>Vision</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Employee (Only Medical Group Name and number in space to the right)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>□ Husband</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Wife</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ No</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>□ U of C Registered Domestic Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ No</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Son</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Daughter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ No</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Son</td>
<td></td>
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<td></td>
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<td>□ Yes</td>
<td>□ No</td>
<td>□ No</td>
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<tr>
<td>□ Daughter</td>
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<td></td>
<td></td>
<td></td>
<td>□ No</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td>□ Son</td>
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<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Daughter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ No</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

Other Insurance Information
Do you or any of your family members have OTHER GROUP MEDICAL COVERAGE? □ Yes □ No
Employed By: Insured’s Name: Date of Birth:

Group Number: Subscriber Number:

Insurance Company Name: Address:

City: State: Zip: Telephone Number:

The other insurance is for:
□ Yourself □ Yourself + One Dependent □ Family
**BENEFITS CHANGE FORM**

**Group Life Insurance**

The University provides benefits eligible employees with a Basic Life Insurance benefit of up to $50,000. Select the amount of Supplemental Life Insurance you want below. If you are electing Supplemental Coverage you must complete the Prudential Insurance Company of America’s Evidence of Insurability process and your coverage election will be effective on the Insurance Company’s approval date.

**Supplemental Life**

Multiple of Your Salary __________ x up to $1,500,000

- [ ] I do not wish to participate in Supplemental Life.

**Dependent Coverage**

Please select life coverage for your Spouse, University of Chicago Registered Domestic Partner, or Dependent Child (up to age 26)

- **Spouse/University of Chicago Registered Same Gender Domestic Partner:**
  - Elect coverage for your Spouse or Same Gender Domestic Partner up $150,000. All elections will require the completion of Prudential’s Evidence of Insurability process and your coverage election will be effective on the Insurance Company’s approval date.
  - [ ] Spouse / U of C Registered Same Gender Domestic Partner
  - Date of Birth (required): ____________
  - Multiples of $10,000 up to $150,000 $ ____________

- **Dependent Child Coverage (up to age 26):**
  - Elect coverage for your dependent children in $2,000 increments up to $10,000. No Evidence of Insurability required.
  - [ ] Dependent Child Coverage (up to age 26)
  - Multiples of $2,000 up to $10,000 $ ____________

**Long Term Disability**

If you are electing to increase your coverage, you must complete the Prudential Insurance Company of America Evidence of Insurability process.

**LTD PLAN SELECTION:** (Please mark an “x” in the appropriate space)

- [ ] I elect to participate in the Basic Plan.
- [ ] I elect to participate in the Optional Plan.
- [ ] I am age 65 or older and I elect to waive participation.

**Personal Accident Insurance**

- [ ] I wish to participate in the Personal Accident Plan.
- [ ] I do not wish to participate in the Personal Accident Plan.

**Select the Coverage Level:**

- [ ] Yourself Only
- [ ] Yourself and Family

Please indicate the amount of coverage. This amount must be in increments of $10,000 with a minimum of $20,000. The maximum PAI benefit level is ten times annual salary to a maximum of $1,000,000.

$ ____________ .00
**BENEFITS CHANGE FORM**

SS# ____________________________

<table>
<thead>
<tr>
<th>Life/Personal Accident Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>I designate the following beneficiary (ies) for Life and Personal Accident Insurance Coverage: <em>(If necessary, use an additional page)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>SS#</th>
<th>Designated Percentage (%)</th>
</tr>
</thead>
</table>

☐ Primary

☐ Contingent

*Will receive the benefit only if Primary beneficiary (ies) are deceased.*

**Flexible Spending Accounts (FSA)**

**Please note:** Your election is binding until the end of the calendar year. You will have until March 15th of the following year to use your account balance before it is forfeited. Expenses/claims must be incurred during the time that you participate in the plan in order to be eligible for reimbursement.

- I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs.

- I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize the University of Chicago to make pretax deductions from my salary on a monthly/bi-weekly basis.

The amount you can contribute to each FSA is limited. For a Health Care FSA, the annual minimum amount you can contribute is $250 and the annual maximum amount is $2,500. For a Dependent Care FSA, the annual minimum amount you can contribute is $250 and the annual maximum amount is $5,000.

*If you are a Highly Compensated Employee, your Dependent Care contribution is limited to a lower amount. Contact the Benefits Office at benefits@uchicago.edu regarding this lower limit.

**Health Care FSA Annual Election**

$__________ *

Health Care Flexible Spending Account is for health care expenses incurred by yourself and your dependents.

Request for change in status ______

**Dependent Care FSA Annual Election**

$__________ *

Dependent Care Flexible Spending Account is for daycare expenses for a dependent child under age 13 or an adult relative (disabled spouse, elderly parent), while you are at work.

Request for change in status ______

Pay schedule (Circle): Biweekly or Monthly

*Annual election will be divided equally based on each pay period.*

**BENEFITS OFFICE ONLY**

<table>
<thead>
<tr>
<th>Per Pay Period Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>$________</td>
</tr>
</tbody>
</table>

*First payday from which a deduction will be made: ___/___/___

**Effective Date of Coverage:**

______

Rev 4.25.13
By signature below I certify that:

I hereby apply for participation in my employer’s benefits plan(s) for those benefits for which I am or may become eligible under the terms and conditions of said plan and any present or future amendments thereto, and subject to acceptance of my enrollment. I hereby authorize my employer to deduct from my earnings the required contributions, if any, toward the cost of this plan(s).

- I understand that I cannot change any of the elections for medical, dental, vision coverage and Flexible Spending Accounts until the next open enrollment period, unless I have a qualifying change in status. Deductions for these plans will be taken on a pre-tax basis.
- If I waived medical coverage, I certify that I have other medical coverage.
- I understand the effect of any pre-tax contributions on my pay.

I authorize the release to and use by the claims processor of any medical information necessary to establish the validity of any claim for benefits for myself or on behalf of my eligible dependents. This authorization shall remain valid from the date signed through the term of coverage of the program. A copy of this authorization shall be as valid as the original. I certify that I have read the provisions hereof which are hereby incorporated in and made a part of this form.

_________________________________________________________________________________________________________________
Employee Name (Please Print)

____________________________________________________________________________________________
Employee Signature

____________________________________________________________________________________________
Date

Please attach all required documentation to forms (marriage certificate, birth certificates, etc.) and return to the BENEFITS OFFICE at:

Human Resources
Benefits Office
The University of Chicago
6054 South Drexel Avenue
Chicago, Illinois 60637
Or
Fax: 773-753-3319

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