University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST. LOUIS

# 2024 Benefits Change Form

☐ Check box if this is a revised enrollment ☐ Check box if you have a J1 VISA.

| Employee Last Name | Employee First Name | MI | Employee ID (not SSN) | |
|---|---|---|---|---|
| Street | | | Hire Date | Date of Birth |
| City | State / ZIP / Home Phone | | Work Phone | Gender |

## Benefit Election Instructions

Changes to your medical, dental or vision enrollment elections, at a time other than the Annual Enrollment change period, require that you have a change in family or employment status. The change form must be submitted to your campus contact or the HR Service Center within ***31 days from the date of the event***. Campus contact and HRSC information is located on the last page of this document.

- If you have one of the changes listed under Section I, Family/Employment Status Change, complete Sections I, II, III, IV and V.
- In Section II, provide information only for the dependent(s) for which you are making changes.
  - Proof of relationship documentation must be submitted to your campus contact or the HR Service Center within 31 days from the date of the event. Dependents added to the plan due to a loss of coverage will need to provide proof of coverage loss in addition to proof of relationship within 31 days from the dates of the event.
- Make your benefit selections (Section III).
  - Your contributions for the medical, dental, vision, basic life insurance option B (2x annual base salary) and long-term disability buy-up plan are deducted on a before-tax basis unless you are exempt from federal or state taxes or specifically elect otherwise.
  - After the initial enrollment, if you want to change how you pay your share of the benefit costs from an after-tax to a before- tax basis, or vice versa, you can only do so during the Annual Enrollment change period.
  - Changes to other benefit elections may have specific requirements or restrictions and must be consistent with the family status change. Please contact your campus contact for details on changes to benefits other than medical, dental or vision insurance.
- Update your beneficiaries (Section IV) if needed. Please note, beneficiaries can be updated at any time during the plan year.
- Read, sign and date the Authorization and Acknowledgements (Section V), before returning this form to your campus contact or the HR Service Center. Please make and keep a copy for your records.

## I. Family/Employment Status Change

Effective Date of Change: _____

| ☐ **Add coverage due to:** | ☐ **Cancel coverage due to:** | **Dependent Name Changes Only** |
|---|---|---|
| ☐ Marriage/Divorce | ☐ Death | _____ Current First & Last Name |
| ☐ Spouse loses other medical coverage | ☐ Divorce/Legal separation | _____ New First & Last Name |
| ☐ Spouse's coverage was University of Missouri coverage | ☐ Termination of Sponsored Adult Dependent Partnership (must complete affidavit of termination) | Effective Date of Change: _____/_____/_____ |
| ☐ Spouse's employer discontinues coverage or makes significant change in coverage | ☐ Dependent becomes ineligible | |
| ☐ Birth/Adoption | ☐ Spouse obtains other health coverage | |
| ☐ Child/ren lose other coverage | ☐ Spouse's coverage is University of Missouri coverage | |
| ☐ Child/ren of new spouse | ☐ Child obtains other health coverage | |
| ☐ Employee loses other coverage through: _____ | ☐ Cancel or decrease Additional Life Insurance only (no family/employment status change required) | |

| Employee Last Name | Employee First Name | MI | Employee ID (not SSN) |
|---|---|---|---|
| | | | |

II. **Dependent Information** Complete the following information for any dependent(s) to be added or cancelled. Changes should also be reflected in Section III.

| Dependent/ Spouse Name | Relationship (Spouse/SAD*** or Child) | Gender (M/F) | Birth Date (MM/DD/YY) | Social Security Number | ADD**** | | | | REMOVE | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Medical | Dental | Vision | Life | Medical | Dental | Vision | Life |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

*** If you enroll a Sponsored Adult Dependent (SAD) on your plan, you will also need to complete an Affirmation.
****If you are adding a dependent to your insurance, you will be required to provide Proof of Relationship (POR).

## III. Enrollment Options

### Medical Insurance

Pre-tax unless this box is checked for an after-tax contribution ☐

| | Employee Only | Employee + Spouse | Employee + Children | Employee + Family |
|---|---|---|---|---|
| Healthy Savings Plan** | ☐ (01) $62.00 | ☐ (02) $177.00 | ☐ (04) $156.00 | ☐ (05) $303.00 |
| Custom Network Plan (Columbia area) | ☐ (25) $92.00 | ☐ (26) $259.00 | ☐ (28) $242.00 | ☐ (29) $437.00 |
| Custom Network Plan (St. Louis area) | ☐ (73) $92.00 | ☐ (74) $259.00 | ☐ (76) $242.00 | ☐ (77) $437.00 |
| PPO Plan | ☐ (13) $187.00 | ☐ (14) $457.00 | ☐ (16) $435.00 | ☐ (17) $735.00 |
| Tiered PPO Plan (for Kansas City and Rolla areas) | ☐ (85) $187.00 | ☐ (86) $457.00 | ☐ (87) $435.00 | ☐ (88) $735.00 |

**If you enroll in the Healthy Savings Plan, you will also need to complete the HSA Enrollment Form.
**Note:** The Healthy Savings Plan is not an eligible plan for employees who have a J1 VISA.

**Waive medical coverage**
Decline ☐ (W) waive

### Dental Insurance

Pre-tax unless this box is checked for an after-tax contribution ☐

| **Dental** | Employee Only | Employee + Spouse | Employee + Children | Employee + Family |
|---|---|---|---|---|
| Dental Base Plan | ☐ (01) $15.53 | ☐ (02) $31.05 | ☐ (03) $37.68 | ☐ (04) $53.21 |
| Dental Buy-up Plan | ☐ (13) $26.18 | ☐ (14) $52.30 | ☐ (15) $82.85 | ☐ (16) $111.04 |
| Decline | ☐ (W) waive | | | |

### Vision Insurance

Pre-tax unless this box is checked for an after-tax contribution ☐

| **Vision** | Employee Only | Employee + Spouse | Employee + Children | Employee + Family |
|---|---|---|---|---|
| | ☐ (01) $5.06 | ☐ (02) $10.08 | ☐ (03) $11.00 | ☐ (04) $17.41 |
| Decline | ☐ (W) waive | | | |

| Employee Last Name | Employee First Name | MI | Employee ID (not SSN) |
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## Disability and Life Insurance

**Basic Life**

Option B is pre-tax unless this box is checked for an after-tax contribution ☐

| Option A (1x annual base salary & age graded) | Option B (2x annual base salary & age graded)* |
|---|---|
| ☐ (01) $0.00 | ☐ (02) $0.022 per $1,000 of coverage |

*Statement of Health is required for coverage increase. Learn more at umurl.us/life.

**Accidental Death and Dismemberment**

After-tax contribution

| | $25,000 | $50,000 | $75,000 | $100,000 | $125,000 | $150,000 |
|---|---|---|---|---|---|---|
| AD&D – Self | ☐(01) $0.35 | ☐(02) $0.70 | ☐(03) $1.05 | ☐(04) $1.40 | ☐(05) $1.75 | ☐(06) $2.10 |
| AD&D – Family | ☐(07) $0.50 | ☐(08) $1.00 | ☐(09) $1.50 | ☐(10) $2.00 | ☐(11) $2.50 | ☐(12) $3.00 |
| Decline | ☐(W) Waive | | | | | |

**Dependent Life - Spouse/Sponsored Adult Dependent**

After-tax contribution (rates will vary based on age)

| $10,000 | $20,000 | $30,000* | $40,000* | $50,000* | $60,000* | $70,000* | $80,000* | $90,000* | $100,000* |
|---|---|---|---|---|---|---|---|---|---|
| ☐ (01) | ☐ (02) | ☐ (03) | ☐ (04) | ☐ (05) | ☐ (06) | ☐ (07) | ☐ (08) | ☐ (09) | ☐ (10) |

Decline ☐ (W) waive

*$10,000 and $20,000 amounts are guaranteed approval only if being added due to a new marriage or loss of University of Missouri coverage. All other situations require Statement of Health. Learn more at umurl.us/life.

**Dependent Life-Child(ren)**

After-tax Contribution (rates will vary based on age)

| $5,000 | $10,000 | $15,000 | $20,000 | $25,000 |
|---|---|---|---|---|
| ☐ (01) $0.32 | ☐ (02) $0.64 | ☐ (03) $0.96 | ☐ (04) $1.28 | ☐ (05) $1.60 |

Decline ☐ (W) waive

**Additional Life**

After-tax contribution (rates will vary based on age).

| 1X annual base salary | 2X annual base salary* | 3X annual base salary* | 4X annual base salary* | 5X annual base salary* | 6X annual base salary* | 7X annual base salary* | 8X annual base salary* |
|---|---|---|---|---|---|---|---|
| ☐ (01) | ☐ (02) | ☐ (03) | ☐ (04) | ☐ (05) | ☐ (06) | ☐ (07) | ☐ (08) |

Decline ☐ Waive

- If you have a change in family or employment status, you may increase, decrease, or cancel your existing coverage. Statement of Health is required for coverage increases. If you previously waived this coverage, you will not be able to enroll until the next Annual Enrollment
- A change in family or employment status is **not** required to cancel or decrease your existing coverage.

**Long-Term Disability**

Option B is pre-tax unless this box is checked for an after-tax contribution ☐

| Core Plan (Option A) | Buy-up Plan (Option B)* |
|---|---|
| ☐ (01) $0.00 | ☐ (02) $0.14 per $100 of monthly income |

*Statement of Health (SOH) is required. Learn more at umurl.us/life.

**Short-Term Disability**

Option B is pre-tax contribution

| Core Plan (Option A) | Buy-up Plan (Option B) |
|---|---|
| | ☐ (02) $0.74 per $100 of monthly income |

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## IV. Beneficiary Designation

Complete this section only if you wish to make a change to your current beneficiary designation.

If you're naming only one primary beneficiary, put 100% in the percent column. If you're naming more than one primary beneficiary, you must indicate what percentage each is to receive. The total **MUST** equal 100%. The same applies for your contingent beneficiaries.

☐ I do not want to change my beneficiaries at this time.

### Basic Life Insurance Plan Beneficiar(y/ies)

**Primary**

| Name | Address | Relationship | Social Security Number | Share (%) |
|---|---|---|---|---|
| Name | Address | Relationship | Social Security Number | Share (%) |
| Name | Address | Relationship | Social Security Number | Share (%) |

**Contingent**

| Name | Address | Relationship | Social Security Number | Share (%) |
|---|---|---|---|---|
| Name | Address | Relationship | Social Security Number | Share (%) |
| Name | Address | Relationship | Social Security Number | Share (%) |

### Additional Life Insurance Plan Beneficiar(y/ies)

**Primary** ☐ Beneficiar(y/ies) same as Basic Life Insurance Plan

| Name | Address | Relationship | Social Security Number | Share (%) |
|---|---|---|---|---|
| Name | Address | Relationship | Social Security Number | Share (%) |
| Name | Address | Relationship | Social Security Number | Share (%) |

**Contingent**

| Name | Address | Relationship | Social Security Number | Share (%) |
|---|---|---|---|---|
| Name | Address | Relationship | Social Security Number | Share (%) |
| Name | Address | Relationship | Social Security Number | Share (%) |

### Accidental Death & Dismemberment Insurance Plan Beneficiar(y/ies)

**Primary** ☐ Beneficiar(y/ies) same as Basic Life Insurance Plan

| Name | Address | Relationship | Social Security Number | Share (%) |
|---|---|---|---|---|
| Name | Address | Relationship | Social Security Number | Share (%) |
| Name | Address | Relationship | Social Security Number | Share (%) |

**Contingent**

| Name | Address | Relationship | Social Security Number | Share (%) |
|---|---|---|---|---|
| Name | Address | Relationship | Social Security Number | Share (%) |
| Name | Address | Relationship | Social Security Number | Share (%) |

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| | | | |

**Pre-retirement Death Benefit Beneficiar(y/ies)*** *(not applicable to those hired or rehired on or after 10/01/19)*

**Primary** ☐ Beneficiar(y/ies) same as Basic Life Insurance Plan

| Name | Address | Relationship | Social Security Number | Share (%) |
|---|---|---|---|---|
| Name | Address | Relationship | Social Security Number | Share (%) |
| Name | Address | Relationship | Social Security Number | Share (%) |

**Contingent**

| Name | Address | Relationship | Social Security Number | Share (%) |
|---|---|---|---|---|
| Name | Address | Relationship | Social Security Number | Share (%) |
| Name | Address | Relationship | Social Security Number | Share (%) |

*Under the DB Plan or the DB portion of the Hybrid Plan, your spouse is your automatic pre-retirement death beneficiary. If you wish to name someone other than your spouse as your pre-retirement death beneficiary, contact the UM System Office of Human Resources Service Center to request additional forms.

## V. Authorization and Acknowledgements

I hereby make the above elections and I authorize the University of Missouri to deduct/redirect the appropriate amounts from my pay for the coverages elected. (I also hereby authorize the appropriate providers to release any documentation necessary to pay my or my dependents' claims.)

I acknowledge that in the event that I or any of my dependent/s become ineligible for coverage under the Plan, it is my responsibility to inform the University of Missouri System's Office of Human Resources of desired changes in coverage and/or changes in my family status or personal information that affects my benefit coverage or eligibility by completing an enrollment change form within 31 days of the event. (I also understand that any claims paid on behalf of an ineligible individual must be reimbursed to the Plan by me.)

I acknowledge and agree that this document may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. "Electronic signature" shall include faxed versions of an original signature, electronically scanned and transmitted versions of an original signature, and typed signature in a fillable form or typed signature via Adobe Pro.

_____ _____ _____

**Employee ID** **Signature of Employee** **Date**

## Availability of Summary Health Information

As an employee of University of Missouri System, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC, along with a uniform glossary of terms commonly used in health care coverage, is available on the web at: http://umurl.us/SBC. Paper copies are also available, free of charge, by calling the HR Service Center at 1-800-488-5288.

## Campus Contact Information

**HR Service Center**
Phone: (573) 882-2146
Fax: (573) 882-9603
hrservicecenter@umsystem.edu

**Columbia (includes Hospital and System)**
Phone: (573) 882-2146
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**Kansas City**
Phone (816) 235-1621
Fax: (816) 235-5515
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**Rolla**
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