University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST. LOUIS

2019 Benefits Change Form

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 the HR Service Center or your local HR Generalist within ***31 days from the date of the event***. Campus contact 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 the HR Service Center or your local HR Generalist 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 salary) and long-term disability buy-up plans 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 the HR Service Center or your local HR Generalist. Please make and keep a copy for your records.

I. Family Status Change

Effective Date of Change: _____

☐ **Add coverage due to:**	☐ **Cancel coverage due to:**	**Dependent Name Changes Only**
☐ Marriage/Divorce	☐ Death	
☐ Spouse loses other medical coverage	☐ Divorce/Legal separation	_____ Current First & Last Name
☐ Spouse's coverage was University of Missouri coverage	☐ Termination of Sponsored Adult Dependent Partnership (must complete affidavit of termination)	_____ New First & Last Name
☐ Spouse's employer discontinues coverage or makes significant change in coverage	☐ Dependent becomes ineligible	Effective Date of Change:
☐ 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: _____		

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II. Dependent Information

Complete the following information for any dependent(s) to be added or cancelled.

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) $43.00	☐ (02) $145.00	☐ (04) $119.00	☐ (05) $235.00
Custom Network Plan (Columbia area)	☐ (25) $82.00	☐ (26) $222.00	☐ (28) $189.00	☐ (29) $346.00
Custom Network Plan (St. Louis area)	☐ (73) $82.00	☐ (74) $222.00	☐ (76) $189.00	☐ (77) $346.00
PPO Plan (includes Tiered PPO for UMKC)	☐ (13) $168.00	☐ (14) $394.00	☐ (16) $342.00	☐ (17) $595.00

**If you enroll in the Healthy Savings Plan, you will also need to complete the HSA Enrollment Form.

Waive medical coverage

Decline ☐ (W) waive – Please indicate reason for waive below:

☐ other coverage ☐ unaffordable ☐ religious reasons ☐ not interested

Dental Insurance

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

Dental	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Dental Plan	☐ (01) $14.76	☐ (02) $29.52	☐ (03) $35.82	☐ (04) $50.58
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
Vision Plan	☐ (01) $5.59	☐ (02) $11.15	☐ (03) $12.17	☐ (04) $19.26
Decline	☐ (W) waive			

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Life Insurance

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

Basic Life	Option A (1 x base salary & age graded)	Option B (2 x base salary & age graded)*
Basic life insurance	☐ (01) $0.00	☐ (02) $0.03 per $1,000 of coverage
Decline	☐ (W) waive	

After-tax contribution

Accidental Death and Dismemberment	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000
AD&D – Self	☐ (01) $0.53	☐ (02) $1.05	☐ (03) $1.58	☐ (04) $2.10	☐ (05) $2.63	☐ (06) $3.15
AD&D – Family	☐ (07) $0.73	☐ (08) $1.45	☐ (09) $2.18	☐ (10) $2.90	☐ (11) $3.63	☐ (12) $4.35
Decline	☐ (W) waive					

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

Supplemental Life*	Supplemental life options are 1, 2 or 3 times your annual base salary. You may elect or increase your supplemental life coverage. Please request the applicable form from your local HR Generalist.

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

Spouse Life	$10,000*	$20,000*	$30,000*	$40,000*	$50,000*
Spouse	☐ (01)	☐ (02)	☐ (03)	☐ (04)	☐ (05)
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 evidence of insurability (EVI). EVI forms may be obtained online at http://umurl.us/benforms.

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

Dependent Life Child(ren)	$5,000*	$10,000*	$15,000*	$20,000*	$25,000*
Dependent Life Child/ren	☐ (01) $0.35	☐ (02) $0.70	☐ (03) $1.05	☐ (04) $1.40	☐ (05) $1.75
Decline	☐ (W) waive				

*$5,000 amount is guaranteed approval only if being added due to birth, adoption or child(ren) of new spouse. All other situations require evidence of insurability (EVI). EVI forms may be obtained online at http://umurl.us/benforms.

*Evidence of Insurability is required. Applicable forms may be obtained from http://umurl.us/LifeEOI.

Disability Insurance

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

Long Term Disability	Core Plan (Option A)	Buy-up Plan (Option B)*
Long Term Disability	☐ (01) $0.00	☐ (02) $0.20 per $100 of monthly income

*Evidence of Insurability is required. Applicable forms may be obtained from http://umurl.us/LTDEOI

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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 make changes to my beneficiaries at this time.

Basic Life Insurance Plan Beneficiary(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 %

Supplemental Life Insurance Plan Beneficiary(ies)

Primary

☐ Beneficiary(s) Same as 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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Accidental Death & Dismemberment Insurance Plan Beneficiary(ies)

Primary ☐ Beneficiary(s) Same as 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 %

Pre-Retirement Death Benefit Beneficiary(ies)

Primary ☐ Beneficiary(s) Same as 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 %

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.)

_____ _____

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.

Contact Information

Columbia, Hospital and System
HR Service Center: (573) 882-2146
Fax: (573) 882-9603
hrservicecenter@umsystem.edu

Rolla
Phone (573) 341-4241
Fax: (573) 341-4984
benefits@mst.edu

Kansas City
Phone (816) 235-1621
Fax: (816) 235-5515
benefits@umkc.edu

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Phone (314) 516-5805
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