# University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST. LOUIS

# 2023 Benefits Enrollment Form

Check box if this is a revise	ed enrollment	Check box if	you have a J1 V	ISA.				
Employee Last Name	Employee	Employee First Name MI		MI	Employee ID (not SSN)			
Street	·				Hire Date	Date of Birth		
City	State	ZIP	Home Phone		Work Phone	Gender		

### **Benefit Election Instructions**

- This form must be completed and returned within 31 days of your date of hire or your benefit eligibility date. If it is not returned within 31 days, you will not be eligible to enroll until the next Annual Enrollment period for a coverage effective date of January 1 following the enrollment period.
- Make your benefit selections in Section I.
  - o Your contributions for the Medical, Dental, Vision, Basic Life (Option B) and Long Term Disability (Buy-up Plan) insurance plans are deducted on a before-tax basis unless you are exempt from federal or state taxes or specifically elect otherwise.
  - o 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.
- Complete Section II, Dependent Information, and provide the required proof of relationship within 31 days from date of coverage if you are covering dependents.
- Complete the Beneficiary Designation Form for your Basic Life, Additional Life, Accidental Death and Dismemberment insurance plans and/or Pre-Retirement Death Benefit.
- Read, sign and date Section III, Authorization and Acknowledgements, before returning this form to your campus contact or the HR Service Center (HRSC). Campus contact and HRSC information is listed on the last page of this document.

I. Enrollment Options

Emolinent Options										
Medical Insurance										
Pre-tax unless this box is checked for an after-tax contribution $\square$										
	l Em	ployee Only	ployee + Children	Em	ployee + Family					
Healthy Savings Plan**		(01) \$58.00		ployee + Spouse (02) \$166.00		(04) \$147.00		(05) \$284.00		
Custom Network Plan (Columbia area)		(25) \$84.00		(26) \$238.00		(28) \$221.00		(29) \$399.00		
Custom Network Plan (St. Louis area)		(73) \$84.00		(74) \$238.00		(76) \$221.00		(77) \$399.00		
PPO Plan		(13) \$176.00		(14) \$430.00		(16) \$408.00		(17) \$690.00		
Tiered PPO Plan (for Kansas City and Rolla areas)		(85) \$176.00		(86) \$430.00		(87) \$408.00		(88) \$690.00		
**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 and Vision Insur	ance									
<u> </u>	Pre-tax unless this box	is checked for an	after-tax contributio	on 🗆						
Dental	Employee Only	Employe	e + Spouse	Employee + Chi	ldren Emp	Employee + Family				
	□ (01) \$15.53 □ (13) \$22.46	□ (02) \$ □ (14) \$		□ (03) \$37.68 □ (15) \$72.13		04) \$53.21 16) \$96.44				
Decline	☐ (W) waive									
_				_						
Г	Pre-tax unless this box	1		1	Idea - Fran	laves i Familie				
L	Employee Only		e + Spouse	Employee + Chi		loyee + Family				
	(01) \$5.06	☐ (02) :	\$10.08	□ (03) \$11.00		(04) \$17.41				
Decline	☐ (W) waive									
Disability and Life Insu	rance									
	Option B is pre-tax	unless this box is	checked for an afte	er-tax contribution □	I					
Basic Life	Option A (1x annua	l base salary & ag	e graded)	Option B (2x annua	al base salary & a	ge graded)				
	□ (01) \$0.00			□ (02) \$0.022 pe	r \$1,000 of covera	age				
Decline	☐ (W) waive									
Assidental Death and	After toy contribution									
Accidental Death and Dismemberment	After-tax contribution \$25,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000				
AD&D – Self		□ (02) \$0.70	□ (03) \$1.05	□ (04) \$1.40	□ (05) \$1.75	□ (06) \$2.10				
AD&D – Family	_ ``	□ (08) \$1.00	□ (09) \$1.50	□ (10) \$2.00	□ (11) \$2.50	□ (12) \$3.00				
Decline	□ (W) waive			, , ,	, , ,					
	After-tax contribution	on (rates will vary b	pased on age)							
Dependent Life-	\$10,000*	\$20,000*	\$30,000	\$40,	000*	\$50,000*				
Spouse/Sponsored Adult	t									
Dependent*	D (04)	F (00)			(0.4)	- (OF)				
D !!	□ (01)	□ (02)	□ (03)		(04)	□ (05)				
Decline	☐ (W) waive *Evidence of Insurability (EOI) is required. Learn more about EOI at umurl.									
		'	Evidence of Insura	bility (EOI) is require	ed. Leam more at	oout EOI at umun.us/iile.				
	After-tax contribution	on (rates will vary l	based on age)							
Dependent Life-Child(ren	\$5,000	\$10,000	\$15,000	\$20,	000	\$25,000				
	□ (01) \$0.32	□ (02) \$0.6	4 🛭 (03)	\$0.96 □	(04) \$1.28	□ (05) \$1.60				
Decline	☐ (W) waive									
Additional Life*			based on age). Ac our additional life co		are 1, 2 or 3 time	s your annual base				
	1x annual base sa		nual base salary*	3x annual bas	e salan/*					
	□ (01)			□ (03)	o balary					
Decline	□ (W) waive	(-	,	(,						
	*Evidence of Insura	*Evidence of Insurability (EOI) is required for amounts over 1x annual base salary. Learn more about EOI at								
	umurl.us/life.									
	0 :				_					
Laura Tama Biratini			cnecked for an after	er-tax contribution [						
Long Term Disability	Core Plan (Option	A)		Buy-up Plan (Option B)						
	□ (01) \$0.00			⊔ (02) \$0.14 p	er \$100 of month	ly income				

# II. Dependent Information Complete the following information for any dependent(s) to be added or cancelled. Dependent/ Relationship Gender Birth Date Social ADD\*\*\*\* REMOVE

Dependent/ Spouse Name	Gender (M/F)	Social Security Number	ADD***	*			REMOVE			
			Medical	Dental	Vision	Life	Medical	Dental	Vision	Life

<sup>\*\*\*</sup> 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. 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: 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 Fax: (573) 882-9603

hrservicecenter@umsystem.edu

Kansas City

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

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

St. Louis

Phone (573) 882-2146 Fax: (573) 882-9603 umslbenefits@umsl.edu