University of Pittsburgh

Office of Human Resources
Benefits Department
Phone: 412-624-8160 Fax: 412-624-3485

Benefits Enrollment Form

Medical Health Sciences Foundation (MHSF)

For HR Benefits Department Use Only	
Effective Date	Employee#
Processed By	Process Date

1. Employee Data

____
Name (Last, First, M.I.)

____
Email (Preferred)

2. Type of Enrollment

□ New Hire *Start/Hire Date*_____________
□ Status Change *Event Date*_________________

3. Benefit Credit

☑ Monthly $50 contribution from the University

4. UPMC Medical Plans *(Choose A & B or C)*

(a) Choose your Medical Plan Option
□ Panther Gold Advantage Network (HMO)
□ Panther Advocate (PPO)
□ Panther Plus (PPO)
□ Panther Basic (PPO) Qualified High Deductible Health Plan (QHDHP) with Optional Health Savings Account (HSA)
□ I elect to contribute $______.___ per pay period to my HSA. I understand I cannot participate in a Health Savings Account and Health Care Flexible Spending Account in the same plan year. Individual Maximum: $3,350; Age 55+ increase $4,350. Family Maximum: $6,650; Age 55+ increase $7,650.
□ Waive Optional Health Savings Account (HSA)

(b) Choose your Level of Coverage
□ Individual
□ Parent/Child(ren)
□ Two Adults
□ Family

(c) Choose to Not Participate
□ Waive Medical Coverage

5. United Concordia Dental Plans *(Choose A & B or C)*

(a) Choose your Dental Plan Option
□ Concordia Plus (DHMO)
□ Concordia Flex I
□ Concordia Flex II

(b) Choose your Level of Coverage
□ Individual
□ Individual plus One Dependent
□ Family

(c) Choose to Not Participate
□ Waive Dental Coverage

6. Davis Vision Plans *(Choose A & B or C)*

(a) Choose your Vision Plan Option
□ Fashion Excellence
□ Designer Gold

(b) Choose your Level of Coverage
□ Individual
□ Individual plus One Dependent
□ Family

(c) Choose to Not Participate
□ Waive Vision Coverage

7. Flexible Spending Accounts *(Choose A to elect or B to waive)*

(a) Choose your Flexible Spending Account(s)

□ Health Care Spending Account (Min. $10/Max. $212.50, Max. of $318.75 for less than 12 month pay frequency) Contribution per pay period $_____.___
Expenses related to medical, dental and/or vision services for you and your dependents.

□ Dependent Care Spending Account (Min. $10/ Max. $416.67, Max. of $625 for less than annual pay frequency) Contribution per pay period $_____.___
Expenses related to child care (dependents under 13 years old) and/or those who are incapable of self-care.

□ Parking Spending Account (Min. $25/Max. $212.50) Contribution per pay period $_____.___
Parking expenses associated with your employment. (Excludes University pre-tax parking)

□ Mass Transit Spending Account (Min. $10/Max. $130) Contribution per pay period $_____.___
Expenses related to public transportation to or from work outside of Allegheny County.

(b) Choose to Not Participate
□ Waive Health Care Spending Account
□ Waive Dependent Care Spending Account
□ Waive Parking Spending Account
□ Waive Mass Transit Spending Account

8. Aetna Group Life Insurance

☑ The University provides coverage in the amount of 1.0x Salary ($50,000 Maximum)

Choose your Optional Life Insurance coverage*

□ 1.0x Salary □ 3.0x Salary □ 5.0x Salary
□ 1.5x Salary □ 3.5x Salary □ 5.5x Salary
□ 2.0x Salary □ 4.0x Salary □ 6.0x Salary
□ 2.5x Salary □ 4.5x Salary □ Waive coverage

*Completion of the Evidence of Insurability Statement may be required by Aetna Life Insurance Company in order to enroll in coverage.

9. Aetna AD&D Insurance

☑ The University provides coverage in the amount of 1.0x Salary ($50,000 Maximum)

Choose your Optional Accidental Death and Dismemberment (AD&D) Insurance coverage*

□ 1.0x Salary □ 3.0x Salary □ 5.0x Salary
□ 1.5x Salary □ 3.5x Salary □ 5.5x Salary
□ 2.0x Salary □ 4.0x Salary □ 6.0x Salary
□ 2.5x Salary □ 4.5x Salary □ Waive coverage

*Completion of the Evidence of Insurability Statement may be required by Aetna Life Insurance Company in order to enroll in coverage.

10. Aetna Dependent Life Insurance

(a) Choose your Aetna Dependent Group Term Life Plan Option for Spouse/Domestic Partner coverage*

□ $10,000 □ $15,000 □ $20,000 □ $50,000
□ $75,000 □ $100,000 □ Waive coverage

(b) Choose your Aetna Dependent Group Term Life Plan Option for Child(ren)

□ $5,000 □ $10,000 □ Waive coverage

*Completion of the Evidence of Insurability Statement may be required by Aetna Life Insurance Company in order to enroll in coverage.

Pre-Tax Selections

Medical, dental, and vision coverage, in addition to the Flexible Spending Accounts, will be deducted on a pretax basis. This reduces the employee's federal income and social security taxes. The Health Care Flexible Spending Account will also reduce state income taxes for employees who elect it.

11. Member Data

Relationship	Last Name, First Name, M.I.	Social Security Number	Date of Birth (mo./day/yr.)	Check Selection(s) Medical Add	Medical Waive	Dental Add	Dental Waive	Vision Add	Vision Waive	Practice Code (4 Digits) Panther Gold HMO Only	Provider ID (Last 6 Digits) Concordia Plus DHMO Only
Self Sex: M F											
Spouse/Partner Sex: M F											
Child Sex: M F											
Child Sex: M F											
Child Sex: M F											
Child Sex: M F											

If adding more than four children, check this box and continue on an additional attached signed form. ☐

Documentation and Required Information

All applicable documentation must be submitted to the Office of Human Resources Benefits Department with this enrollment form; otherwise, your election(s) will not be put into effect.

- If you are making an election to cover (for the first time) a spouse, domestic partner, and/or child(ren) with medical, dental, and/or vision coverage, documentation of the relationship is required.
  - For a spouse, present a copy of the marriage certificate.
  - For a domestic partner, please visit http://www.hr.pitt.edu/dompartner for the Affidavit of Domestic Partnership and requirements.
  - For dependent children, present a copy of the birth certificate(s). Paperwork for adopted children or stepchildren is also applicable.
- Social security numbers are required (if applicable) for dependents covered under the medical, dental, and/or vision coverage.
- If you are making a qualified status change, documentation is required. Please see http://hr.pitt.edu/benefits/qualified for examples.

12. Certification and Signature

I understand that:

- My benefit selections will remain in effect and may only be changed during the annual open enrollment period or due to a qualified status change permitted under the University of Pittsburgh Welfare Benefit Plan.
- If I check “Waive”, I and/or eligible dependents will not be covered for any of the above benefit options.
- If I elect not to enroll in any University medical plans, I will not be eligible for a subsidy on the exchange and that I need to have proof of alternative medical coverage under another plan.
- If I withdraw from a plan during the open enrollment period or due to a qualified status change and request that my payroll deduction be cancelled accordingly, I relinquish my rights to coverage under the designated terms and conditions. If I desire to participate again, after withdrawal I may do so only at designated times.
- The University contribution for Medical coverage includes a benefit credit and I authorize the University to adjust my pay accordingly through payroll deduction.
- If I have the right to recover expenses incurred for my own or my dependent’s care from another person or organization that may have caused my own or my dependent’s injury or illness, the University of Pittsburgh Welfare Benefit Plan has the right to recover the full amount it paid for my own or my dependent’s care and that I have a legal obligation to help recover the amounts the Plan paid. The Plan reserves the right and is entitled to be repaid the entire amount of any amount awarded to me or my dependents, regardless of the amount of the award we actually receive.
- That the Plan may disclose my personal health information as described in the University of Pittsburgh’s Notice of Privacy Practices.

I certify that all of the information provided above is true and correct and is being provided for the purpose of securing insurance benefits for me or other persons eligible under this insurance benefit program.

I further acknowledge that it is unlawful for any person to make a false or inaccurate statement for the purpose of acquiring insurance benefits for themselves or any other person, and further acknowledge and agree that any false or misleading statement herein may affect eligibility for benefits and may result in discipline by the University of Pittsburgh (up to and including termination of employment) to the extent otherwise permitted by law.

______________________________ Signature

______________________________ Date

Forms are only accepted via fax (412-624-3485), mail or in-person drop off. Forms are NOT accepted via e-mail because of the University’s security policy on the transmission of personal information.