This election form shows the insurance options you may choose, contingent upon the relationship of the monthly employee cost to the “pay year type” and monthly amount of your contract salary. For appointments in the spring term, the amount for insurance benefits is automatically doubled January through April; the actual monthly amount is withheld September through December. After you have reviewed the monthly rate schedule and the applicability of the accrual rate, check the box next to the coverage you want or action you wish to take effect.

### 1. Name
(Print Last, First, Middle Initial) | Social Security Number (xxx-xx-xxxx) | Effective Date
---|---|---

### 2. Reason for Submitting Form/Acknowledgment

- **NEW ENROLLMENT**
  - Elect or Waive Plans
  - Complete Entire Form

- **CHANGE ENROLLMENT/UPDATE OF INFORMATION**
  - Elect or Waive Plans (Qualified Event Subject to Review)
  - Complete Only Applicable Sections of Form, and Name, SSN, and Signature Section
  - Also Complete a Separate Change in Status Form.

I acknowledge that my selections will remain in effect and may only be changed during the annual open enrollment period or due to status change qualified by regulations.

Initials ___________________ Date _______________________

### 3. UPMC MEDICAL*
(Elect only one or waive.) If elected, complete Data Information, Section 6.

- Panther Gold Advantage Network
  - Individual
  - Parent/Child/Children
  - Two Adults
  - Family

- Panther Premier
  - Individual
  - Parent/Child/Children
  - Two Adults
  - Family

- Panther Basic
  - Individual
  - Parent/Child/Children
  - Two Adults
  - Family

- Panther Plus
  - Individual
  - Parent/Child/Children
  - Two Adults
  - Family

- Panther Advocate
  - Individual
  - Parent/Child/Children
  - Two Adults
  - Family

- Waive — I elect not to participate.

### 4. DAVIS VISION*
(Elect only one or waive.) If elected, complete Data Information, Section 6.

- Vision Fashion Excellence Plan
  - Individual
  - Parent/Child/Children
  - Two Adults
  - Family

- Vision Designer Gold Plan
  - Individual
  - Parent/Child/Children
  - Two Adults
  - Family

- Waive — I elect not to participate.

### 5. UNITED CONCORDIA DENTAL*
(Elect only one or waive.) If elected, complete Data Information, Section 6.

- PLUS Managed Care Plan
  - Individual
  - Individual Plus One Adult or Child
  - Family

- FLEX I Standard Plan
  - Individual
  - Individual Plus One Adult or Child
  - Family

- FLEX II Standard Plan
  - Individual
  - Individual Plus One Adult or Child
  - Family

- Waive — I elect not to participate.

*PRETAX SELECTIONS EMPLOYEE COSTS REDUCE FEDERAL INCOME AND SOCIAL SECURITY TAXES

CONTINUED ON OTHER SIDE
6. MEDICAL, VISION, DENTAL, and DEPENDENT LIFE DATA INFORMATION SECTION

Complete if Medical, Vision, Dental, and/or Dependent Life is elected.

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, vision, dental, and/or dependent life coverage, documentation of the relationship is required.
  - For a spouse, present a copy of the marriage certificate.
  - For a domestic partner, contact the Office of Human Resources Benefits Department to schedule an appointment for review of a completed Affidavit of Domestic Partnership.
  - 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, vision, dental, and/or dependent life coverage.

- If you are making an election to remove a spouse or domestic partner because of the end of a relationship, a copy of the divorce decree or dissolution form is required.

For Self/Spouse/Domestic Partner

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>VISION</th>
<th>DENTAL</th>
<th>RELATIONSHIP</th>
<th>PCP or Practice Code</th>
<th>PDO Primary Dental Office Code</th>
</tr>
</thead>
<tbody>
<tr>
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<td>☐ ☐</td>
<td>☐ ☐</td>
<td>Self</td>
<td></td>
<td></td>
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<tr>
<td>☐ ☐ ☐</td>
<td>☐ ☐</td>
<td>☐ ☐</td>
<td>Spouse/Partner</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For DEPENDENT CHILD/CHILDREN, you must indicate the Relationship Code of each child using this Relationship Code Key.

For Self/Spouse/Domestic Partner

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>VISION</th>
<th>DENTAL</th>
<th>RELATIONSHIP</th>
<th>PCP or Practice Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ ☐</td>
<td>☐ ☐</td>
<td>☐ ☐</td>
<td>Self</td>
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</tbody>
</table>

For DEPENDENT CHILD/CHILDREN, you must indicate the Relationship Code of each child using this Relationship Code Key.

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>VISION</th>
<th>DENTAL</th>
<th>RELATIONSHIP</th>
<th>PCP or Practice Code</th>
<th>PDO Primary Dental Office Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ ☐</td>
<td>☐ ☐</td>
<td>☐ ☐</td>
<td>Child 1</td>
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<tr>
<td>☐ ☐ ☐</td>
<td>☐ ☐</td>
<td>☐ ☐</td>
<td>Child 2</td>
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<td></td>
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<td>☐ ☐ ☐</td>
<td>☐ ☐</td>
<td>☐ ☐</td>
<td>Child 3</td>
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<td>☐ ☐ ☐</td>
<td>☐ ☐</td>
<td>☐ ☐</td>
<td>Child 4</td>
<td></td>
<td></td>
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<tr>
<td>☐ ☐ ☐</td>
<td>☐ ☐</td>
<td>☐ ☐</td>
<td>Child 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

7. CERTIFICATION/SIGNATURE

I understand that my selections will remain in effect and may only be changed during the annual open enrollment period or due to a status change qualified by regulations. I also understand that the University contribution for medical insurance includes a benefit credit and authorize the University to adjust my pay accordingly through payroll deduction. I hereby authorize a provider of any covered service to furnish the medical information and records necessary to process claims. I understand that I and/or eligible family members will not be covered if Waive is checked for any of the above selections. 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 canceled accordingly, I understand that I am relinquishing my rights to coverage under the designated terms and conditions and am aware that, if I desire after withdrawal to participate again, I may do so only at designated times. I further 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, to the extent otherwise permitted by law.

Signature __________________________ Date __________________________

Social Security Number __________________________ Daytime Phone Number __________________________