2017 BENEFITS ELECTION FORM

MOREHOUSE SCHOOL OF MEDICINE
Updated 02/07/2017

Banner ID: Ex. (**M00012345**) | | | | | | | | | | Date of Hire ☐ New Hire ☐ Status Change

Last Name: First Name: M.I.

SSN Gender DOB:

Contact Number Marital Status:

Address:

City State Zip Code

You must make an election for each benefit (even if declining coverage). All rates are effective January 1, 2017.

1. MEDICAL: UnitedHealthcare (Choose one option below): All rates are Bi-Weekly. **Original birth certificate is required for adding any child dependents. Original marriage certificate is required for adding a spouse.**

Basic Option

- ◯ Employee Only $32.58
- ◯ Employee + Spouse $141.98
- ◯ Employee + Child(ren) $95.28
- ◯ Employee + Family $207.24

High Option

- ◯ Employee Only $59.97
- ◯ Employee + Spouse $219.54
- ◯ Employee + Child(ren) $163.70
- ◯ Employee + Family $320.45

◯ **DECLINE MEDICAL COVERAGE (If selected, please complete Employee Declination Acknowledgement on page 3)**

2. DENTAL: UnitedHealthcare

(Choose one option below):

- ◯ Employee Only $2.04
- ◯ Employee + Spouse $8.14
- ◯ Employee + Child(ren) $6.14
- ◯ Employee + Family $13.01

◯ **DECLINE DENTAL COVERAGE**

3. VISION: UnitedHealthcare

(Choose one option below):

- ◯ Employee Only $0.32
- ◯ Employee + Spouse $1.14
- ◯ Employee + Child(ren) $0.86
- ◯ Employee + Family $1.83

◯ **DECLINE VISION COVERAGE**

Required Dependent Information (ONLY If Enrolling Dependent(s) in Coverage)

Social Security Numbers are legally required for covered dependents by the Centers for Medicare and Medicaid Services.

Relationship	Name	DOB:	SSN:	Gender:

Additional Dependents

Please add First Name, Last Name, DOB, SSN, and Gender.
Please add one dependent per line.

Additional Dependents:

4. BASIC LIFE & AD&D: Basic Life is 2x your base annual salary up to $500,000. This coverage is provided to you at **no cost.** You must designate a beneficiary.

Beneficiary	Relationship	Name	DOB:	Gender:	SSN:	
						%
						%
						%
						%
						%

Beneficiary Total (Must Equal 100%)

5. EMPLOYEE SUPPLEMENTAL LIFE: You may purchase up to 1x your base annual salary up to $500,000. A **Statement of Health** will be required for amounts over $200,000. Beneficiary for Supplemental Life will be the same as Basic Life unless noted otherwise.

◯ Enroll ◯ Decline Coverage

6. EMPLOYEE SUPPLEMENTAL AD&D: You may purchase up to 1x your base annual salary up to $500,000.

◯ Enroll ◯ Decline Coverage

7. SUPPLEMENTAL SPOUSE LIFE: **There must be an election for the Employee Supplemental Life in order to purchase coverage for a spouse.** Choose life insurance for your spouse in units of $5,000 up to a maximum of $150,000 (**cannot exceed 50% of the employee's base annual salary**). A **Statement of Health** will be required for amounts over $50,000.

◯ Enroll ◯ Decline Coverage

Benefit Amount

Spouse Name: DOB: SSN: Gender:

8. SUPPLEMENTAL DEPENDENT CHILD LIFE: There must be an election for the Employee Supplemental Life in order to purchase coverage for a dependent child. Choose life insurance for your dependent children in units of $2,500 up to a maximum of $10,000. Amount must be equal per child.

◯ Enroll Benefit Amount

◯ Decline Coverage

Child:		DOB:		SSN		Gender:	
Child:		DOB:		SSN		Gender:	
Child:		DOB:		SSN		Gender:	
Child:		DOB:		SSN		Gender:	
Child:		DOB:		SSN		Gender:	

9. SHORT TERM DISABILITY:

◯ Enroll

◯ Decline Coverage

10. FLEXIBLE SPENDING ACCOUNT (FSA): Elect to participate in the Flexible Spending Account plan for the current calendar year. You can contribute to your Health Care Account and to your Dependent Care Account each calendar year.

◯ Enroll

◯ Decline Coverage

Health Care Contribution (***Annual Limits: Min. $200, Max $2,600***):

Health Care Contribution: *Per Pay Period Amount:

Dependent Care Contribution (***Annual Limits: Min $200, Max $5,000***):

Dependent Care Contribution: *Per Pay Period Amount:

**Per Pay Period calculations are based on 26 pay periods and may not reflect your actual bi-weekly deduction.*

By default, United Healthcare will make Automatic Reimbursement payments from your Health Care FSA for expenses submitted to, but not payable by, your medical plan. Expenses will be automatically reimbursed through your FSA and will be incurred by you (and/or your spouse and/or your eligible dependents) and will not be reimbursed by another plan. You cannot use the expenses reimbursed through the FSA program as deductions or credits when filing your individual income tax return. To opt out of Automatic Reimbursement visit www.myuhc.com.

Acknowledgement/Signature

I certify that I have read the benefits PowerPoint summary and understand the benefits for which I am enrolling. I hereby authorize my employer to make applicable changes, as noted above, to my current benefit elections and to deduct from my salary, under the Section 125 premium conversion, in the amount necessary to pay for the coverage(s) elected on this form. Such elections will remain in effect and cannot be changed during the plan year, unless the change is due to and consistent with a change in family status.

Employee Signature: _____ Date: _____

Typing your name serves as your signature

ONLY Complete Below if Declining Coverage

EMPLOYEE DECLINATION ACKNOWLEDGEMENT

If you wish to decline coverage for yourself and/or your dependents, you must sign below and provide a reason for declining coverage for yourself and any dependents.

Coverage under another employer's medical plan:

Employer Name: _____ Plan Name: _____ Plan #: _____

Other reason(s): _____

Employee Signature: _____ Date: _____

Typing your name serves as your signature

I acknowledge that I have been given the opportunity to enroll myself and/or eligible dependents in my employer's medical (including dental and vision) plan(s). I am declining to enroll myself and/or eligible dependents in all or some of the stated plans.

Submit

Basic Life and Basic AD&D	Provided at no cost to you.
Employee Supplemental Life	$.30 per $1,000 of coverage
Supplemental Spouse Life	$.30 per $1,000 of coverage
Supplemental Child(ren) Life	$.20 per $1,000 of coverage
Employee Supplemental AD&D	$0.025 per $1,000 of coverage
Short-Term Disability (STD)	$0.24 per $10 of weekly covered benefit
Long-Term Disability (LTD)	Provided at no cost to you.

Enter Annual Salary: [ ]

Premium Calculation Examples:

Employee Supplemental Life

Example: Employee earning $45,200 per year elects Supplemental Life of 1 times earnings. Earnings are rounded to the next higher $1,000 multiple ($46,000 in this example).

$46,000 x $0.30 = $13,800 ÷ $1,000 = $13.80 per month

($13.80 x 12 months) = $165.60/yr.

$165.60/yr. ÷ 26 pay periods = $6.37 bi-weekly

Supplemental Spouse Life

There must be an election for the Employee Supplemental Life in order to purchase coverage for a spouse.

Example: Employee enrolls spouse in the Supplemental Spouse Life plan at the $20,000 coverage level.

$20,000 x $0.30 = $6,000 ÷ $1,000 = $6.00 per month

($6.00 x 12 months) = $72.00/yr.

$72.00/yr. ÷ 26 pay periods = $2.77 bi-weekly

Premium Calculation Worksheet:

Employee Supplemental Life and Supplemental Spouse Life

[ ] X $0.30 [ ] / 1000 = [ ] per mo.

[ ] per month X 12 months = [ ] per year

[ ] per year / 26 pay periods = [ ] bi-weekly

Note: The calculations are the same for Employee Supplemental Life and Supplemental Spouse Life.

Employee Supplemental Life: $500,000 Maximum
Supplemental Spouse Life: $150,000 Maximum

Employee Supplemental AD&D

Example: Employee elects Supplemental AD&D. Coverage matches the Supplemental Life coverage of $46,000.

$46,000 x $0.025 = $1,150 ÷ $1,000 = $1.15 per month

($1.15 x 12 months) = $13.80/yr.

$13.80/yr. ÷ 26 pay periods = $.53 bi-weekly

Note: Employee Supplemental AD&D: $500,000 Maximum

Employee Supplemental AD&D

[ ] X $0.025 = [ ] / 1000 = [ ] per mo.

[ ] per month X 12 months = [ ] per year

[ ] per year / 26 pay periods = [ ] bi-weekly

Supplemental Child(ren) Life

There must be an election for the Employee Supplemental Life in order to purchase coverage for a dependent child.

Example: Employee enrolls his 3 children in the Supplemental Child Life plan at the $10,000 coverage level (for each child). Premium is based on coverage level, not the aggregate of the children's coverage.

$10,000 x $0.20 = $2,000 ÷ $1,000 = $2.00 per month

($2.00 x 12 months) = $24/yr.

$24/yr. ÷ 26 pay periods = $.92 bi-weekly covers all 3 children at $10,000 of coverage for each child

Supplemental Child(ren) Life

[ ] X $0.20 = [ ] / 1000 = [ ] per mo.

[ ] per month X 12 months = [ ] per year

[ ] per year / 26 pay periods = [ ] bi-weekly

Short-Term Disability (STD)

Example: Employee earning $45,200 ($869.23 per week) elects STD coverage. The maximum weekly benefit is 60% of weekly earnings up to $2,500 per week. In this example, the STD benefit is $521.54 per week (60% of $869.23)

$521.54 x $0.24 = $125.17 ÷ $10 = $12.52 per month

($12.52 x 12 months) = $150.24/yr.

$150.24/yr ÷26 pay periods = $5.78 bi-weekly

Short-Term Disability (STD)

[ ] / 52 weeks = [ ] weekly earnings

[ ] X .60 = [ ] maximum weekly benefit

[ ] X $0.24 = [ ] / $10 = [ ] per mo.

[ ] X 12 months = [ ] per year

[ ] per year / 26 pay periods = [ ] bi-weekly