TOTAL REWARDS
HUMAN RESOURCES
UNIVERSITY OF ROCHESTER

Employee ID _____
(Required)

2021 Benefits Program Enrollment Form - Incoming Residents and Fellows

Please Complete ALL Applicable Sections. Once completed, email your form to totalrewards@rochester.edu. If you have any questions, contact the Office of Total Rewards at (585) 275-2084.

Employee Information

Name (Last, First, Initial): _____

Address: _____

_____

Gender (M/F): _____ **Date of Birth (MM/DD/YYYY):** _____ **Phone Number:** _____

E-mail Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

- **Date of Appointment(MM/DD/YYY):** _____

University Health Care Plans - Use the drop down to make your selection.

Please Select a Plan or Select to Waive Coverage	*Please Select Your Dependent Coverage Level*

University Dental Plans* - Use the drop down menu to make your selection.

Please Select a Plan or Select to Waive	*Please Select Your Dependent Coverage Level**

**Excellus is the Third-Party Administrator (TPA) for the Dental Plans*

***(Employee only coverage is considered single. Employee plus one or more dependents is considered family.)*

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Dependent	Name (Last, First)	Date of Birth (MM/DD/YY)	Gender (M/F)	Social Security Number*	Should be enrolled in healthcare (Y/N)	Should be enrolled in dental (Y/N)
Spouse						
Domestic Partner**						
Family Member	☐ Child to age 26 ☐ DP's Child ☐ Handicapped ***					
Family Member	☐ Child to age 26 ☐ DP's Child ☐ Handicapped ***					
Family Member	☐ Child to age 26 ☐ DP's Child ☐ Handicapped ***					

☐ I have additional dependents and my Additional Dependents Form will be submitted along with this form.

***Beginning with the 2015 Plan Year, the Affordable Care Act Regulations requires all insures and self-insured employer groups (UR) to report to the IRS the social security numbers (SSN) for each individual (employees and dependents) to whom the group provides minimum essential health care coverage (MEC) intended primarily to support the IRS' enforcement of the individual mandate.** In addition to your own, please provide the SSN for each dependent to be enrolled under your University Health Care Plan. Under Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), third-party administrators of self-funded plans like the University of Rochester's Health Care Plans are required to meet new reporting requirements. Reportable information includes Social Security Numbers of individuals whose health care plan coverage,begins on or after 1/01/09, who are 45 or older, are covered by Medicare, or have end-stage renal disease.

*** If an employee adds a Domestic Partner, they will need to submit the Certification of Domestic Partner Status form and Domestic Partner Tax Affidavit on the Total Rewards website if applicable*

**** A Handicapped Dependent form is REQUIRED for these eligible dependents. Forms are available online at www.rochester.edu/totalrewards and at the Total Rewards website. Please return completed forms to the address listed on the form.*

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Health Savings Account (HSA)

(This option requires enrollment in the University's YOUR HSA-Eligible Plan)

If Aetna is your Third-Party Administrator (TPA), your HSA will be administered by PayFlex. If Excellus is your TPA, your HSA will be administered by HSA Bank.

☐ Health Savings Account (Max $3,600 with single University's YO**U**R HSA-Eligible Plan coverage, Max $7,200 with family University's YO**U**R HSA-Eligible Plan coverage. If you are age 55 or older you may contribute an additional $1,000) Annual* Health Savings Account contribution of $_____

Limited Purpose Flexible Spending Account (available only if you are contributing to a HSA)

☐ Limited Purpose FSA (Min $100 and Max $2,750 annually)
Annual* Limited Purpose FSA contribution of $_____

***The annual amount will be pro-rated for a deduction each pay period based on the number of pay periods remaining to be paid in the calendar year (2021).**

Please note: Annual maximum contributions are pro-rated if enrollment in the University YOUR HSA-Eligible Plan occurs after January 1 of the calendar year (2021).

Please note: A plan that covers an employee and one or more dependents is considering family coverage for HSA contribution limits.

Health Savings Account (HSA) Eligibility Criteria

To determine your ability to enroll in a Health Savings Account per the IRS Guidelines you will need to meet ALL the requirements below.

- ✓ You must elect coverage under the University's YO**U**R HSA-Eligible Plan for 2021.
- ✓ You cannot be covered by any other health plan (including spousal health insurance), except what the IRS permits.
- ✓ You cannot elect nor be covered by another person's Health Care Flexible Spending Account or Health Reimbursement Arrangement for 2021.
- ✓ You cannot be enrolled in any part of Medicare, Tricare, Medicaid or state health care programs.
- ✓ You cannot or will not be claimed as a dependent on another person's tax return for 2021.
- ✓ You cannot have received Veteran's Administration health benefits in the past 90 days (preventive, dental and vision is permitted).

☐ I declare that I **do not** meet all the requirements above to the best of my knowledge

☐ I declare that I **do** meet all the requirements above to the best of my knowledge

If you do not meet the requirements to enroll in a Health Savings Account you may choose to enroll in a Flexible Spending Account.

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Flexible Spending Accounts (FSA)

Please be sure to read the FSA Election of Reimbursement & Compensation Reduction Agreement which can be found on the Total Rewards website prior to electing an FSA.

☐ Health Care FSA* (Min $100, Max $2,750 annually) Annual Healthcare FSA contribution of $_____

☐ Dependent Care FSA* (for Child/Daycare Services for dependent children up to age 13 or a qualified handicapped spouse or dependent child/tax dependent) (Min $100, Max $5,000 or $2,500 if married and filing separate tax returns)
Annual Dependent Care FSA contribution of $_____

*The annual amount will be pro-rated for a deduction each pay period based on the number of pay periods remaining to be paid in the calendar year.

Please Note: Federal non-discrimination guidelines require the University of Rochester to test Dependent Care FSA annually to ensure highly compensated employees, as defined under IRS guidelines, do not disproportionally contribute to the Dependent Care FSA. Highly compensated employees, who earned over $130,000 in the 2020 Plan Year, may have their FSA maximum contribution amount reduced if the test results do not meet federal guidelines.

Authorize Elections and Certify Dependent Eligibility

Please click within the box to read and scroll through all the terms and conditions

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and each of my family members who are covered under the Plans are bound by the terms and conditions of the plan documents and associated administrative documents as from time to time are in effect and that these documents have been available (and will continue to be available) to me online at www.rochester.edu/totalrewards in hard copy at the University of Rochester Total Rewards Office. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information to the Plan's Third-Party Administrators and insurance carriers. I make this acknowledgment and agreement on behalf of myself and each person who now or in the future accepts coverage under the terms of the Plan applicable to my coverage (who may include, for example, my spouse, and my eligible family dependents).

I understand that if I have knowingly included any false information or enrolled ineligible dependents, that coverage may be canceled, upon one month's written notice and any benefit claims may be denied, and that I may be subject to disciplinary action including termination of employment to the extent permitted by law. I have read and understand the information defining dependent eligibility under the University of Rochester Health and Dental Plans. I certified that each of my dependents covered under my health care and/or dental plan(s) meet the University's current dependent eligibility requirements, and that I agree to notify the Total Rewards Office if their status changes during the plan year.

☐ I agree to the above terms and conditions.

Signature

☐ I acknowledge that providing my electronic approval is equivalent to signing the document and I understand that my electronic signature is binding. I understand that it may take up to one full pay period to process this change.

First and Last Name:

Date:

Please review the form for completion and send to totalrewards@rochester.edu. Incomplete or unsigned forms will not be processed. If you have any questions, please contact the Office of Total Rewards at 585.275.2084.