2021 Benefits Program Enrollment Form for Members of SEIU

If you are transferring into a benefit eligible position, you must complete all sections of this form (online enrollment is unavailable). Please fill out this form electronically and email the completed form to totalrewards@rochester.edu. If you have any additional questions, call 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):_____

Employee ID#:_____ Phone Number:_____

E-mail Address:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Long-Term Disability (LTD)

NOTE: To add/increase LTD coverage after your initial enrollment eligibility period you must complete and submit a statement of health for approval by the insurance company. Please contact the Leave Administration Office to obtain the required form.

Please Choose a Coverage Level

☐ I wish to apply for FULL coverage to which I am now entitled or may become entitled to in the future under the UR Long-Term Disability (LTD) Plan.

☐ I wish to LIMIT my coverage under the UR Long-Term Disability (LTD) Plan. I understand that the coverage to which I am now entitled or may become entitled will apply to my base salary up to $20,000, but will not protect any part of my present or future salary which is above $20,000 per year.

☐ FOR PART-TIME STAFF ONLY: I wish to WAIVE my coverage under the UR Long-Term Disability (LTD) Plan. I understand that I will have no insurance coverage under the LTD Plan if I am totally disabled longer than six months.

NOTE: To apply for a waiver of the one year service requirement for LTD coverage because you had Long-Term Disability Insurance through a previous employer-sponsored group plan, please complete the section below.
I hereby certify that I was previously employed by _____ (previous employer) and was covered there under a group long-term disability plan providing income benefits for a minimum of 5 years for disability due to sickness. Date my coverage ended _____ (not more than 3 months prior to my UR appointment). The plan was insured by _____ (name of insurance company).

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Flexible Spending Accounts (FSAs)

Please be sure to read the FSA Election of Reimbursement & Compensation Reduction Agreement prior to electing an FSA. Your FSA TPA will be LBS (Excellus).

Please Make a Selection for Each Option

Health Care FSA (Minimum $100, Maximum $2,750 annually)

☐ I am electing an ANNUAL* Health Care FSA contribution of $_____

☐ I do not wish to contribute to a Health Care FSA

Dependent Care FSA (for day care expenses) (Minimum $100, Maximum $5,000 annually or $2,500 if married and filing separate tax returns)

☐ I am electing an ANNUAL* Dependent Care FSA contribution of $_____

☐ I do not wish to contribute to a Dependent Care FSA

*Indicate Annual Pledge Amount for each account (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).

Authorize Elections (LTD and/or FSA)

I acknowledge and agree that by signing this enrollment/change form and subsequently accepting services, I and each of my family members who is 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 or in hard copy at the University of Rochester Total Rewards Office.

If electing an FSA, please see the conditions below.

I authorize the University to deduct (after-tax except for FSA contributions) from my wages or salary the amount(s) to pay my share of the cost of being covered by plan benefits.

By electing an FSA, I and the University of Rochester, hereby agree that my cash compensation will be reduced by the amount set forth in the FSA section of this form pro-rated for each pay period during 2021 (or during such portion of the year as remains after the date of this agreement). I have read and understand the information contained in the Flexible Spending Account Election of Reimbursement & Compensation Reduction Agreement.

☐ 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