TOTAL REWARDS
HUMAN RESOURCES
UNIVERSITY OF ROCHESTER

Employee ID_____
(Required)

2022 Benefits Program Enrollment Form for ACA Eligible Covered Employees

Please Print - Please Complete ALL Applicable Sections

Employee Information

Name (Last, First, Initial) ***Please Print:*** _____

Address: _____

_____

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

E-mail Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

University Health Care Plans

Please Select a Plan or Select to Waive	*Please Select Your Dependent Coverage Level*
☐ YO**UR** HSA-Eligible Plan ☐ YO**UR** PPO Plan ☐ Waive Medical Coverage	☐ Employee Only Coverage ☐ Employee and Spouse/Domestic Partner Coverage ☐ Employee and Child(ren) Coverage ☐ Family Coverage
Third-Party Administrator (TPA) **Excellus**	

Dependent Information

Spouse's Information	**Name (Last, First)**	**Gender (M/F)**	**Social Security Number*** **(Required field for all dependents*)**	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**
	_____				
***Domestic Partner's Information**	**Name (Last, First)**	**Gender (M/F)**	**Social Security Number*** **(Required field for all dependents*)**	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**
	_____				

Please return completed forms to: Office of Total Rewards, 60 Corporate Woods, Suite 310, P.O. Box 270453, Rochester, NY 14627; or Email: TotalRewards@Rochester.edu

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Family Member's Information	**Name (Last, First)** _____ __ Child to age 26 __ DP's Child __ Handicapped**	**Gender (M/F)**	**Social Security Number*** **(Required field for all dependents*)**	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**
Family Member's Information	**Name (Last, First)** _____ __ Child to age 26 __ DP's Child __ Handicapped**	**Gender (M/F)**	**Social Security Number*** **(Required field for all dependents*)**	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**
Family Member's Information	**Name (Last, First)** _____ __ Child to age 26 __ DP's Child __ Handicapped**	**Gender (M/F)**	**Social Security Number*** **(Required field for all dependents*)**	**Date of Birth (MM/DD/YY)**	**Should be enrolled in Healthcare (Y/N)**

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 Office of 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 Office. Please return completed forms to the address listed on the 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.

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Health Savings Account (HSA)

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

Your HSA will be through HSA Bank.

☐ Health Savings Account (Max $3,650 with single University's YO**UR** HSA-Eligible Plan coverage, Max $7,300 with family University's YO**UR** HSA-Eligible Plan coverage. If you are age 55 or older you may contribute an additional $1,000)
Annual (not per pay period) Health Savings Account contribution of $_____

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**UR** HSA-Eligible Plan for 2022.
- ✓ 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 2022.
- ✓ 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 2022.
- ✓ 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

Signature: _____

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Please review this form for completion and sign and date below.
Incomplete and/or unsigned forms will not be processed.

Authorize Elections and Certify Dependent Eligibility

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 or in hard copy at the University of Rochester Office of Total Rewards. 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 acknowledgement 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 eligible family dependents).

I authorize the University to deduct from my wages or salary the amount(s) indicated on the University of Rochester 2021 Health Care Plans Premium Rate Sheet to pay my share of the cost of being covered by University benefit plans I have elected. I understand that such pay deductions will generally be taken on an after-tax basis, with the exception of premium contributions toward the cost of Health Care Plan coverage for tax-qualified dependents, or Health Savings Account (HSA) contributions, which will be taken on a before-tax basis. I understand that if I am enrolled in coverage through the University and not receiving paychecks from the University, I must continue to pay my share of the premium for the Health Care Plan coverage to continue coverage through the University. If the University does not receive payment for the coverage, the coverage will be terminated on the last day of the month in which the premium has been paid in full and notification of the coverage cancellation will be sent to the home address from the University. Employees whose coverage has been canceled due to non-payment will not be eligible to re-enroll in Health Care coverage until the next Open Enrollment period and until the premiums past due are paid to the University. Employees returning to work with an outstanding balance will be subject to arrears billing.

By electing an HSA, I and the University of Rochester, hereby agree that my cash compensation will be reduced by the annual amount set forth in the HSA section of this form, pro-rated by the number of pay periods in 2022 (or by the number of pay periods remaining after the date of this agreement) and deducted from my pay in equal installments.

I understand that if I have knowingly included any false information or enrolled ineligible dependents, that coverage may be cancelled, 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 plan. I certified that each of my dependents covered under my health care plan (s) meet the University's current dependent eligibility requirements, and that I agree to notify the Office of Total Rewards if their status changes during the plan year.

Signature: _____ Date: _____

If you have any questions, please contact the University of Rochester Office of Total Rewards at (585) 275-8382 or (585) 275-2084

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