TOTAL REWARDS
HUMAN RESOURCES
UNIVERSITY OF ROCHESTER

10/2022

2023 BENEFITS PROGRAM ENROLLMENT FORM FOR NEW HIRES AND NEWLY BENEFIT ELIGIBLE EMPLOYEES

UNIVERSITY OF ROCHESTER

Please fill out this form electronically and email the completed form to totalrewards@rochester.edu.

Name: _____ _____ _____
LAST FIRST M.I.

Employee ID Number: _____ **Date of Birth:** ____ / ____ / _____

Email Address: _____

Daytime Phone Number: (____) ____ - _____ **Gender (M/F):** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Pay Cycle: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly

Date of Hire/Change to Eligible Status: ____ / ____ / _____

HEALTH CARE & DENTAL PLANS

SELECT A HEALTH CARE PLAN[1]	SELECT YOUR DEPENDENT COVERAGE LEVEL
☐ YOUR HSA-Eligible Plan	☐ Employee Only Coverage
☐ YOUR PPO Plan	☐ Employee and Spouse/Domestic Partner Coverage
☐ Waive Medical Coverage	☐ Employee and Child(ren) Coverage
	☐ Family Coverage

SELECT A DENTAL PLAN[1]	SELECT YOUR DEPENDENT COVERAGE LEVEL[2]
☐ Traditional Dental Plan	☐ Employee Only Coverage
☐ Medallion Dental Plan	☐ Family Coverage
☐ Waive Dental Coverage	

[1] Excellus BlueCross BlueShield is the TPA for Medical and Dental Plans.

[2] Employee Only coverage is considered single coverage. Family Coverage is coverage for the employee plus one or more dependents.

DEPENDENT INFORMATION

	Name (Last, First)	Date of Birth (MM/DD/YY)	Gender (M/F)	Social Security Number[3]	Should be enrolled in healthcare (Y/N)	Should be enrolled in dental (Y/N)
Spouse						
Domestic Partner[4]						
Family Member	☐ Child to age 26 ☐ Domestic Partner's Child ☐ Handicapped[5]					
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Family Member	☐ Child to age 26 ☐ Domestic Partner's Child ☐ Handicapped[5]					

☐ 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.

[3] Required field for all dependents.

[4] If an employee adds a Domestic Partner, they will need to submit the Certification of Domestic Partner Status form. If applicable, they should complete the Domestic Partner Tax Affidavit. Both forms are available on the Total Rewards website.

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

LONG-TERM DISABILITY (LTD)

Residents and fellows are automatically enrolled in LTD. No further action is required; please skip to the next section and visit rochester.edu/working/hr/leave for additional information.

Please note: To add/increase coverage after your initial enrollment period you would have to complete and submit a statement of health for approval by the insurance company.

Choose a Coverage Level:

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

☐ LIMITED Coverage – I wish to limit my coverage under the UR Long-Term Disability (LTD) Plan. I understand that the coverage for which I am now entitled or may become entitled will apply to my base salary up to $36,000, but will not protect any part of my present or future salary that is above $36,000 per year.

☐ WAIVE coverage (for PART-TIME faculty and 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 for longer than six months.

Waive One-Year Service Requirement:

To apply for a waiver of the one-year service requirement for LTD coverage because you have 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)

FLEXIBLE SPENDING ACCOUNTS (FSA)

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

☐ **Health Care FSA** *($100 minimum and $2,850 maximum annual contribution)*

Annual[6] Health Care FSA Contribution: $_____

☐ **Dependent Care FSA[7]** *($100 minimum and $5,000 maximum annual contribution)*

Annual[6] Dependent Care FSA Contribution: $_____

[6] Your annual contribution amount will be divided among your paychecks based on the number of pay periods remaining in the calendar year.

[7] Dependent Care FSAs are used for child/daycare services for dependent children up to age 13 or a qualified handicapped spouse or dependent child/tax dependent.

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 $135,000 in the 2022 Plan Year, may have their FSA maximum contribution amount reduced if the test results do not meet federal guidelines. If applicable, you might consider dividing your desired annual maximum contribution between you and your spouse/partner.

HEALTH SAVINGS ACCOUNT (HSA)

You must be enrolled in the University's HSA-Eligible Plan in order to contribute to an HSA.

Maximum HSA Contribution Amounts for 2023:

$3,850 is the maximum HSA contribution for those with single coverage.
$7,750 is the maximum HSA contribution for those with employee & spouse/domestic partner coverage, employee & children coverage, or family coverage.

If you are age 55 or older, you may contribute an additional $1,000.

☐ **Health Savings Account** – Annual[8] HSA Contribution: $ _____

LIMITED PURPOSE FSA

Available only to those who are also contributing to an HSA.

☐ **Limited Purpose FSA** *($100 minimum & $2,850 maximum annual contribution)*
Annual[8] Limited Purpose FSA Contribution: $ _____

HSA ELIGIBILITY CRITERIA

Per the IRS Guidelines, individuals must meet ALL of the requirements below in order to contribute to an HSA.

- You must elect coverage under the University's YOUR HSA-Eligible Plan for 2023.
- 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 2023.
- 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 2023.
- 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 of the requirements above, to the best of my knowledge.

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

[8] Your annual contribution amount will be divided among your paychecks based on the number of pay periods remaining in the calendar year.

Please review this form for completion and sign and date below. Incomplete and/or unsigned forms will not be processed. If you have any questions, please contact the Office of Total Rewards at totalrewards@rochester.edu or (585) 275-2084.

AUTHORIZE ELECTIONS AND CERTIFY DEPENDENT ELIGIBILITY.

Please click within the box to scroll.

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 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 authorize the University to deduct from my wages or salary the amount(s) indicated on the University of Rochester 2023 Health Care and Dental 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, flexible spending accounts (FSA) contributions, 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 and Dental 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

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 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 Office of Total Rewards 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.

FIRST & LAST NAME: _____

DATE: _____