TOTAL REWARDS
HUMAN RESOURCES
UNIVERSITY OF ROCHESTER

8/2024

2024 BENEFITS PROGRAM QUALIFYING EVENT CHANGE FORM

Please fill out this form electronically and email the completed form to totalrewards@rochester.edu.
Forms must be received by the Office of Total Rewards within 60 days of the qualifying event.
You may need to provide supporting documentation with this form in order for changes to be processed.

Name: _____ _____ _____
LAST FIRST M.I.

Employee ID Number (*required*): _____ **Date of Birth:** _____

Email Address: _____

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

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

QUALIFYING EVENTS

Please click within the box to scroll.

NOTE: This section must be completed for any request to change University Health, Dental, or Flexible Spending Account elections outside of the annual open enrollment period due to a qualifying event. Changes due to a qualifying event must be received within 60 days of the qualifying event. Coverage changes will generally be effective on the date of the qualifying event. Where a coverage change is effective mid-way through a payroll

Please select the appropriate qualifying event:
Check only one box

☐ Legal Marriage/Domestic Partnership[1]

☐ Legal Separation or Divorce

☐ Termination of Domestic Partnership

☐ Birth of a Child/Adoption of a Child

☐ Gain Eligibility of Medicaid/Medicare

☐ Loss Eligibility of Medicaid/Medicare

☐ Approved Leave (i.e.FMLA, Military Leave)

☐ Return from Leave (i.e.FMLA, Military Leave)

☐ Retirement

☐ Other:_____

Loss of Coverage *(Date of Qualifying Event requested below is the 1st date in which you no longer have your existing coverage)*

☐ Spouse/Domestic Partner Open Enrollment Parent/Dependent Child

☐ Spouse/Dependent Passes Away

☐ Dependent Gains Eligibility Through Their Own Employer or Parent's Coverage

☐ Change in Cost of Care for Dependent Care FSA

☐ Significant increase in the employee's share of health care premiums

☐ Significant decrease in the employee's share of health care premiums

[1] A Certification of Domestic Partners Status Form is REQUIRED for eligible domestic partners. Also, if your domestic partner and/or his/her dependent children qualify as your tax dependent under Federal law, an Affidavit of Domestic Partner's (Opposite-Sex and Same-Sex) Federal Tax Dependent Status for University Health Benefit Plans Form is required. Forms are available online at www.rochester.edu/totalrewards.

Based on your qualifying event, you are eligible to make the following changes:
Please click within the box to scroll.

Are you or any of your dependents currently covered under another University Health or Dental Plan through a relative employed by the University, please provide the name of the relative below:

☐ No
☐ Yes

If yes, please provide the name of the relative: _____

DESIRED ACTION

Please check your desired action(s) and include the date of your qualifying event. If you need to provide supporting documentation, the date of the qualifying event **must** coincide with your supporting documentation. *For loss of coverage events, the Date of Qualifying Event requested below is the 1st date in which you no longer have your existing coverage.*

☐ I am requesting a change to my Health Care Plan and/or Dental Plan elections due to a Qualifying Event[2].

Date of Qualifying Event:

☐ I am requesting a change to my Flexible Spending Account (FSA) elections due to a Qualifying Event[2].

- ☐ Health Care FSA
- ☐ Dependent Care FSA

Date of Qualifying Event:

☐ I would like to add or remove a dependent(s) to/from my Health Care Plan and/or Dental Plan elections due to a Qualifying Event[2].

Date of Qualifying Event:

Changes to VSP Vision Care due to a qualifying event should be completed on YOURBenefitsExtras.com.

If you would like to make changes to your Health Savings Account, you may do so at any point throughout the year by filling out the HSA Contribution Form.

[2]Completed forms must be received by the Office of Total Rewards within 60 days of the qualifying event. Incomplete forms cannot be processed.

DEPENDENT INFORMATION

☐ I am not adding or removing a dependent.
Skip to the next page.

☐ I am adding or removing a dependent.
Please complete the below chart, including information for ALL dependents that you would like to include on your plan(s) moving forward.

	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]					
Family Member	☐ Child to age 26 ☐ Domestic Partner's Child ☐ Handicapped[5]					
Family Member	☐ Child to age 26 ☐ Domestic Partner's Child ☐ Handicapped[5]					
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 from the Office of Total Rewards. Please return completed forms to the address listed on the form.

UNIVERSITY HEALTH CARE PLANS

☐ I am not making any changes to my health care plan

Skip to the next section.

☐ I am making one or more changes to my health care plan.

Please use the drop downs to select a plan, TPA, and coverage level below.

SELECT A PLAN	SELECT YOUR DEPENDENT COVERAGE LEVEL

UNIVERSITY DENTAL PLANS

☐ I am not making any changes to my dental plan

Skip to the next section.

☐ I am making one or more changes to my dental plan.

Please use the drop downs to select a plan and coverage level below.

SELECT A PLAN[6]	SELECT YOUR DEPENDENT COVERAGE LEVEL[7]

[6] Excellus BlueCross BlueShield is the TPA for Dental Plans.

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

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.

☐ I am not making any changes to my FSA.
Skip to the next section.

☐ I am making one or more changes to my FSA.
Please specify your changes in the section below.

Maximum FSA Contribution Amounts for 2024:

Health Care FSA and Limited Purpose FSA - $100 minimum and $3,050 maximum annual contribution.

Dependent Care FSA - $100 minimum and $5,000 maximum or $2,500 if married and filing separate tax returns annual contribution.

☐ **I would like to begin contributing to an FSA.**

Annual Health Care FSA Contribution: $_____

Annual Dependent Care FSA[8] Contribution: $_____

Annual Limited Purpose FSA[9] Contribution: $_____

☐ **I am currently contributing to an FSA at the University and would like to change my contribution amount.**

Annual Health Care FSA Contribution: $_____

Annual Dependent Care FSA[8] Contribution: $_____

Annual Limited Purpose FSA[9] Contribution: $_____

Please note: Your FSA annual election cannot be reduced below the amount of payroll contributions already deducted or claims submitted for the calendar year if it would result in a negative balance, and the change must be consistent with the qualifying event. If you do not use your FSA contribution at the end of the plan year, then you will forfeit the funds (rollover rules may apply). You will not be refunded for any unused FSA contributions. Additionally, benefit changes may take up to 1-2 pay periods to process.

[8] 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.

[9] Limited Purpose FSAs are for employees that are enrolled in the HSA-Eligible Plan and are contributing to an HSA.

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 $150,000 in the 2023 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.

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 (585) 275-2084. Please email completed forms and required documentation to the Office of Total Rewards at totalrewards@rochester.edu.

AUTHORIZE ELECTIONS AND CERTIFY DEPENDENT ELIGIBILITY

I acknowledge and agree that by signing this enrollment form and subsequently accepting.

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 2024 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

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 Office of Total Rewards if their status changes during the plan year.

☐ I agree to the above terms and conditions.

Acknowledgment

☐ I have reviewed the Qualifying Event Matrix to determine if supporting documentation is needed. If applicable, supporting documentation will be emailed to totalrewards@rochester.edu along with this form.

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 & LAST NAME: _____

DATE: _____