UNIVERSITY OF ROCHESTER

2019 Benefits Program Qualifying Event Change Form

(Retiree) Please Print– Please Complete ALL Applicable Sections

Retiree Information

Name (Last, First, Initial):_____

Address:_____

_____

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

Retiree/Employee ID#:_____ Phone Number:_____

E-mail Address:_____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Retirement Date (Last Working Date): _____

Please Check Desired Action

Please complete with date of qualifying event

❑ I am requesting a change to my Health and/or Dental Plan elections due to a Qualifying Event*
Date of Qualifying Event:_____

❑ I am requesting a change to my spouse/domestic partner's Health Plan elections due to gaining/losing eligibility for Medicare/Medicaid.*
Date of Qualifying Event:_____

❑ I would like to ADD a dependent(s) to my Health and/or Dental Plan due to a Qualifying Event*
Date of Qualifying Event:_____

❑ I would like to REMOVE a dependent(s) from my Health and/or Dental Plan due to a Qualifying Event*
Date of Qualifying Event:_____

***NOTE: Completed forms must be received by the Office of Total Rewards within 30 days of a qualifying event. For Medicare Advantage Plan changes, forms must be completed prior to the effective date of coverage.**

Please Return Forms

Phone: (585) 275-2084

By Mail:

University of Rochester
Office of Total Rewards
60 Corporate Woods, Suite 310
PO Box 270453, Rochester, NY 14627

In Person:

University of Rochester
Office of Total Rewards
60 Corporate Woods, Suite 310
Rochester, NY 14623

Please Continue to Page 2

UNIVERSITY OF ROCHESTER

2019 Benefits Program Qualifying Event Change Form (Retiree)

Please Print– Please Complete ALL Applicable Sections

Qualifying Events

NOTE: **This section must be completed for any request to change University Health or Dental Account elections outside of the annual open enrollment period due to a qualifying event. Requests must be received within 30 days of the qualifying event to be approved. For Medicare Advantage Plan changes, forms must be completed prior to the effective date of coverage and the coverage effective date is the 1st of the month following the qualifying event date.** Changes due to retirement will be effective the 1st of the month following the retirement date. All other qualifying event changes will be effective the date of the qualifying event or the date the form is completed, whichever is later.

Please Select the Qualifying Event

- ❑ Retirement
- ❑ Legal Marriage/Domestic Partnership*
- ❑ Legal Separation or Divorce
- ❑ Termination of Domestic Partnership
- ❑ Birth of a Child/Adoption of a Child
- ❑ Dependent Gains Eligibility Through Their Own Employer or Parent's Coverage
- ❑ Loss of Coverage
- ❑ Gain Eligibility for Medicare/Medicaid
- ❑ Lose Eligibility for Medicare/Medicaid
- ❑ Retiree/Dependent Open Enrollment
- ❑ Dependent Passes Away
- ❑ Lose Eligibility for Medicare Advantage Plan Due to Change in Permanent Residence
- ❑ Retiree/Dependent Enrolls in Coverage Through Public Health Insurance Exchange/ Marketplace
- ❑ Retiree/Dependent Loses Coverage Through Public Health Insurance Exchange/Marketplace

* 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 and at the Office of Total Rewards. Please return completed forms to 60 Corporate Woods, Suite 310, PO Box 270453, Rochester, NY 14627.

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

Name: _____

Please Continue to Page 3

UNIVERSITY OF ROCHESTER

2019 Benefits Program Qualifying Event Change Form (Retiree)

Please Print– Please Complete ALL Applicable Sections

Spouse's Information	Social Security # (Required field for certain dependents *)	Gender M/F	Date of Birth (MM/DD/YY)	Would you like to cover on your **University Health Care Plan**	Would you like to cover on your **University Dental Plan**
Name:_______________	SS#___________	❑ M ❑ F	___________	❑ YES ❑ NO	❑ YES ❑ NO
Domestic Partner (DP) Information	Social Security # (Required field for certain dependents *)	Gender M/F	Date of Birth (MM/DD/YY)	Would you like to cover on your **University Health Care Plan**	Would you like to cover on your **University Dental Plan**
Name:_______________	SS#___________	❑ M ❑ F	___________	❑ YES ❑ NO	❑ YES ❑ NO
Dependent Children's Information (If your dependent child is Handicapped please check the appropriate box in addition)	Social Security # (Required field for certain dependents *)	Gender M/F	Date of Birth (MM/DD/YY)	Would you like to cover on your **University Health Care Plan**	Would you like to cover on your **University Dental Plan**
Name:_______________ ☐ Employee's Child ☐ DP's Child ☐ Handicapped Child**	SS#___________	❑ M ❑ F	___________	❑ YES ❑ NO	❑ YES ❑ NO
Name:_______________ ☐ Employee's Child ☐ DP's Child ☐ Handicapped Child**	SS#___________	❑ M ❑ F	___________	❑ YES ❑ NO	❑ YES ❑ NO
Name:_______________ ☐ Employee's Child ☐ DP's Child ☐ Handicapped Child**	SS#___________	❑ M ❑ F	___________	❑ YES ❑ NO	❑ YES ❑ NO
Name:_______________ ☐ Employee's Child ☐ DP's Child ☐ Handicapped Child**	SS#___________	❑ M ❑ F	___________	❑ YES ❑ NO	❑ YES ❑ NO

* The Affordable Care Act Regulations requires all insurers and self-insured employer groups (UR) to report to the IRS the social security numbers (SSN) for each individual (retirees 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 in your University Health Care Plan.

** A Handicapped Dependent Form is REQUIRED for these eligible dependents. Forms are available online at www.rochester.edu/totalrewards and at the Office of Total Rewards. Please return completed forms to 60 Corporate Woods, Suite 310, PO Box 270453, Rochester, NY 14627.

 Please Continue to Page 4

UNIVERSITY OF ROCHESTER

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University Dental Plans

Coverage level is determined by dependent elections on Page 3 of this form. Retiree only coverage is considered single, Retiree plus one or more dependents is considered family.

- ❑ I choose to Elect coverage under the University Traditional Dental Assistance Plan
- ❑ I choose to Elect coverage under the University Medallion Dental Plan
- ❑ I choose to Waive University Dental Plan Coverage

University Non-Medicare-Eligible Retiree Health Care Plans

Please Select a Plan or Select to Waive

- ❑ YO**U**R PPO Plan
- ❑ YO**U**R HSA-Eligible Plan
- ❑ Waive University Health Care Plan Coverage

Please Select a Third-Party Administrator

- ❑ Aetna
- ❑ Excellus BlueCross BlueShield

Please Continue to Page 5

UNIVERSITY OF ROCHESTER

2019 Benefits Program Qualifying Event Change Form (Retiree)

Please Print– Please Complete ALL Applicable Sections

University Medicare-Eligible Retiree Health Care Plans

Please Select a Plan or Select to Waive

*If enrolling in GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS or USA Care PPO, you will need to fill out a separate application in conjunction with this form. Enrollment applications for these Medicare Advantage plans must be completed prior to the effective date of coverage. If you are moving from a Medicare Advantage plan to the University Complementary Care Plan or waiving a Medicare Advantage plan, you must complete a disenrollment form prior to the effective date of the change or disenrollment. Enrollment applications and disenrollment forms can be obtained from the Office of Total Rewards.

❑ Preferred Gold Standard HMO-POS (with MVP Part D Prescription Drug) **Requires additional application*

❑ GoldAnywhere PPO (with MVP Part D Prescription Drug) **Requires additional application*

❑ USA Care PPO (with MVP Part D Prescription Drug) **Requires additional application*

❑ Preferred Gold HMO-POS with University Major Medical **Requires additional application*

❑ University Complementary Care Plan with Major Medical

❑ Waive Coverage

Please Select a Third-Party Administrator for Major Medical

*Only if enrolling in either Preferred Gold HMO-POS with University Major Medical or University Complementary Care with Major Medical

❑ Aetna ❑ Excellus BlueCross BlueShield

Medicare Information

Retiree's Name: _____ Medicare Claim #: _____

Hospital (Part A) _____ / _____ / _____* Medical (Part B) _____ / _____ / _____

*If not eligible for Medicare Part A, please give reason: _____

Effective Date: Prescription Drug (Part D) _____ / _____ / _____ ***or* ❑ I choose not to enroll in Part D

Reason for Medicare: ❑ Over-65 ❑ Disability

Spouse/DP's Name: _____Medicare Claim #: _____

Hospital (Part A) _____ / _____ / _____* Medical (Part B) _____ / _____ / _____

*If not eligible for Medicare Part A, please give reason: _____

Effective Date: Prescription Drug (Part D) _____ / _____ / _____ ***or* ❑ I choose not to enroll in Part D

Reason for Medicare: ❑ Over-65 ❑ Disability

****Enrollment in Part D (Prescription Drug Benefit) is voluntary.** Prescription Drug coverage provided as part of the University of Rochester Retiree Health Care Plans, on average for all participants, is expected to be as good as the standard Medicare prescription drug benefits (Creditable Coverage). However, in cases where individuals qualify for special assistance due to limited income or financial resources, Medicare Part D prescription drug benefits may provide more generous coverage than University of Rochester Retiree Health Care Plan coverage.

PLEASE NOTE: If you elect to enroll in Medicare Part D and enroll in the University Complementary Care Plan with Major Medical, Medicare Part D will be the primary payer for your prescription drug benefits with the University Health Care Plan as the secondary payer.

Please Continue to Final Page

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Please Print– Please Complete ALL Applicable Sections

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

Authorize Elections and Certify Dependent Eligibility

I acknowledge and agree that by signing this qualifying event 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 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 other 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 as a Retiree I am responsible to pay my share of the Health and Dental premiums to continue coverage through the University. If the University does not receive payment for my coverage, I understand the coverage will be terminated on the last day of the month for which the premium has been paid in full and notification of the coverage cancellation will be sent to the home address from the University. Retirees enrolled in GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS or USA Care PPO will have coverage terminated in accordance with CMS regulations. I understand if my coverage has been cancelled due to non-payment, I will not be eligible to re-enroll in a Health Care plan or Dental plan until the next Open Enrollment period and until premiums past due are paid to the University.

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. 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 to be 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.

_____ _____

Signature **Date**