St. Louis Community College

HEC

INSURANCE ELECTION FORM For MEDICAL, LIFE/ADD, LTD and STD

Type or Print in ink – corrections or whiteouts must be initialed

Last Name: _____ First _____M.I._____
Address _____ Date Employed Full-Time _____
City _____ Annual Salary_____
State_____Zip _____ Position _____
Home Phone ( ) _____ Work Location_____
Social Security # _____ Work Phone ( ) _____

Enrollment Type: ☐ New Employee ☐ Change Reason for Change: _____ Date of Change: _____

Marital Status:
☐ Single
☐ Married

Employee Category
( ) Administrator ( ) Faculty
( ) Professional ( ) Classified

Is your spouse a full time College employee? ☐ Yes ☐ No

Please check the appropriate box in each insurance election option. An incomplete election form will delay enrollment.

United Healthcare "Standard Plan"

Acct #: 902105

☐ **Employee Only Coverage** ☐ **Family**
☐ **Employee + Spouse** ☐ **Employee + Children**
☐ **Decline Coverage**

On the day your coverage begins will you or any family members be covered by other health insurance or Medicare? ☐ Yes ☐ No If yes, complete the following:

☐ **Medical:** Policy Coverage Dates _____to _____ Policy #_____
Name of Insured____ Insured's Birth Date_____
Insured's Employer_____
Insurance Company Name and Phone #_____

Names of Family Members Covered
_____
_____
_____

☐ **Medicare**: Medicare Claim #_____ Part A - Effective Date_____ Part B - Effective Date_____
Names of Family Members Covered by Medicare_____
Is Medicare eligibility due to ☐ Kidney failure ☐ Disability

Life/Accidental Death & Dismemberment

(You must complete the Designation of Beneficiary form on the back if enrolling for the first time)

☐ **Employee Only Coverage**
☐ **Family Coverage**
☐ **Decline Coverage**

Long Term Disability (LTD)

☐ **60% wage replacement** ☐ **70% wage replacement** ☐ **Decline Coverage**

Voluntary Short Term Disability (STD)

☐ **Elect Coverage** ☐ **Decline Coverage**

REQUIRED FAMILY INFORMATION – Please list yourself and each dependent to be enrolled

Name	Relationship	Sex	Birth Date	Social Security Number
_____	**Self**	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Employee contributions for Medical and LTD insurance premiums will be collected through payroll deduction under the College's Salary Reduction Plan. This pre-tax payment of premiums is permissible under Section 125 of the Internal Revenue Code. IRS regulations and the College's Section 125 Plan require that you **MAY NOT DROP, ADD TO or CHANGE YOUR ELECTED COVERAGE** until the College's next scheduled annual election **unless** you have a **change in family status** which includes: marriage; divorce, death of a spouse or child; birth, adoption or placement for adoption of a child; change in the spouse's employment status or loss of coverage due to a change in the spouse's employment; unpaid leave of absence or a change from full-time to part-time status or vice versa of the employee or spouse; a substantial premium increase or other related family status events that may be provided by applicable law. You have **31 days** from the date of your change in family status to make any enrollment changes to your current insurance; otherwise, changes cannot be made until the next annual election. Election forms are available from Human Resources and the HEC office. Human Resources must receive your election form within the 31-day time limit. Termination of employment by employee is not a change in family status.

SIGNATURE _____ **DATE** _____

Your signature authorizes the College to take payroll deductions for your share of the premium costs for the insurance coverage you elected and acknowledgment that you understand that the deduction for Medical and LTD are a part of the College's Salary Reduction Plan. Your signature also authorizes your physician, hospital or other health care providers to furnish the insurance company with medical information about you and any eligible dependent listed above.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any factual material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

See reverse side for information regarding effective dates of coverage and identification cards.

Office Use Only Coverage Effective: UHC _____ LTD _____ First Premium Due: UHC_____ LTD_____ Life/ADD _____
Life/ADD STD
STD

Important! The Insurance providers require changes to be made within 31days of any qualifying event. For example, upon the birth or adoption of a child, the child must be added within 31 days of the child's birth or effective date of adoption or the child will not be covered until the next annual election.

Effective Dates of Coverage

If you fail to elect coverage for medical, life/accidental death and dismemberment, LTD or STD within 31 days from your date of hire, you will not be able to apply for coverage until the next scheduled annual election unless you have a change in family status. A change in family status includes: marriage, divorce, death of a spouse or child; birth, adoption or placement for adoption of a child; change in the spouse's employment status or loss of coverage due to a change in the spouse's employment; unpaid leave of absence or a change from full-time to part-time status or vice versa of the employee or spouse; a substantial premium increase or other related status events that may be provided by applicable law. Termination of employment by the employee is not a change in family status.

Medical and Life/ADD – Coverage becomes effective on the date you sign the election form, provided you elect coverage within 31 days from your date of hire.

LTD – Coverage becomes effective on the first day of the month following your date of hire, provided you elect coverage within 31 days from your date of hire.

STD – Coverage becomes effective on the date you sign the election form, provided you elect coverage within 31 days from your date of hire.

If you apply for life/ADD, LTD and/or STD after 31 days from your date of hire, the following conditions apply:

Life/ADD – You must complete an evidence of insurability form and coverage must be approved by the insurance company.

LTD - You must complete an evidence of insurability form when applying for the first time or increasing coverage from 60% to 70% and coverage must be approved by the insurance.

STD – Benefits will not be paid for disabilities caused by a pre-existing condition for the first 60 days of disability during the first 12 months from the effective date of coverage.

Identification Cards
Medical Insurance – United Healthcare (UHC) will send identification cards to your home. www.myuhc.com

BENEFICIARY DESIGNATION – LIFE/AD&D: For new enrollment only. DO NOT complete if we have a beneficiary designation on file.
Complete addresses are required

Primary Beneficiary(ies)	**Address**	**Relationship**

Contingent Beneficiary(ies) Will receive benefits in case person (s) listed above are deceased	**Address**	**Relationship**

I hereby designate the above beneficiary(ies) and reserve the right to change my beneficiary(ies) at anytime without the consent of the named beneficiary(ies).

SIGNATURE_____ **DATE**: _____
(Full Legal Name)

Suggested Beneficiary Designations – May be used for primary and/or contingent.

Note: A married woman should be designated by her own name not Mrs. Joe Doe

- One beneficiary – Mary E. Doe, wife
- Two beneficiaries (equal amounts) – John H. and Mary E. Doe, Parents, equally or survivor
- Three or more beneficiaries (equal amounts) – John H. and Mary E. Doe, Parents, and Joan J. Doe, sister, equally or survivor
- Unequal amounts – 75% to Mary E. Doe, wife, if living, otherwise to Jane J. Doe, mother; 25% to Jane J. Doe, mother, if living, otherwise to Mary E. Doe, wife
- To name your estate as beneficiary – write "Estate"

St. Louis Community College

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INSURANCE ELECTION FORM FOR DENTAL AND VISION and VADD

Type or Print in ink – corrections or whiteouts must be initialed

Last Name: _____ First _____M.I._____
Address _____ Date Employed Full-Time _____
City _____ Annual Salary_____
State_____ Zip _____ Position _____
Home Phone ( ) _____ Work Location_____
Social Security # _____ Work Phone ( ) _____

Enrollment Type: ☐ New Employee ☐ Change Reason for Change: _____ Date of Change: _____

Marital Status: ☐ Single ☐ Married

Employee Category ( ) Administrator ( ) Faculty ( ) Professional ( ) Classified/Physical Plant

Is your spouse a full time College employee? ☐ Yes ☐ No

Please check the appropriate box in each insurance election option. An incomplete election form will delay enrollment.

Dental Insurance

☐ CIGNA Dental – PPO - Acct #: 3337816

☐ **Employee Only Coverage** ☐ **Family Coverage**

On the day your coverage begins will you or any family members be covered by other dental insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of Insured_____ Insured's ID#_____
Insured's Employer_____
Name of Dental Plan_____
Address of Dental Plan_____

Names of Family Members Covered by other Dental Insurance
_____
_____
_____

☐ Dental Source Dental – HMO Acct # 106576

☐ **Employee Only Coverage** ☐ **Family Coverage** **(You must choose a dentist from the provider list and enter the dental office ID# below)**

☐ Decline Dental Coverage

Vision Benefits of America Insurance – Acct #: 3592

☐ **Employee Only Coverage** ☐ **Family Coverage** ☐ **Decline Coverage**

Voluntary Accidental Death & Dismemberment (VADD)

(You must complete the Designation of Beneficiary form on the back if enrolling for the first time)

☐ **Employee Only Coverage**
☐ **Family Coverage** **Indicate amount of coverage from rate chart on back $_____**
☐ **Decline Coverage**

REQUIRED FAMILY INFORMATION – Please list yourself and each dependent to be enrolled

Name	Relationship	Sex	Birth Date	Social Security Number	Dental Source Office ID# 1st Choice	2nd Choice
_____	**Self**	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Employee contributions for dental, vision and VADD insurance premiums will be collected through payroll deduction under the College's Salary Reduction Plan. This pre-tax payment of premiums is permissible under Section 125 of the Internal Revenue Code. IRS regulations and the College's Section 125 Plan require that you **MAY NOT DROP, ADD TO or CHANGE YOUR ELECTED COVERAGE** until the College's next scheduled annual election **unless** you have a **change in family status** which includes: marriage; divorce, death of a spouse or child; birth, adoption or placement for adoption of a child; change in the spouse's employment status or loss of coverage due to a change in the spouse's employment; unpaid leave of absence or a change from full-time to part-time status or vice versa of the employee or spouse; a substantial premium increase or other related family status events that may be provided by applicable law. You have **31 days** from the date of your change in family status to make any enrollment changes to your current insurance; otherwise, changes cannot be made until the next annual election. Election forms are available from Human Resources and the HEC's office. Human Resources must receive your election form within the 31-day time limit. Termination of employment by the employee is not a change in family status.

SIGNATURE _____ **DATE** _____

Your signature authorizes the College to take payroll deductions for your share of the premium costs for the insurance coverage you elected and acknowledgment that you understand that the deduction for dental, vision and VADD are a part of the College's Salary Reduction Plan. Your signature also authorizes your physician, hospital or other health care providers to furnish the insurance company with medical information about you and any eligible dependent listed above.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any factual material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

See reverse side for information regarding effective dates of coverage and identification cards.

Office Use Only Coverage Effective: Dental &Vision_____ VADD_____ First Premium Due: Dental_____ Vision_____ VADD_____

Effective Dates of Coverage

If you fail to elect coverage for dental, vision or VADD within 31 days from your date of hire, you will not be able to apply for coverage until the next scheduled annual election unless you have a change in family status. A change in family status includes: marriage, divorce, death of a spouse or child; birth, adoption or placement for adoption of a child; change in the spouse's employment status or loss of coverage due to a change in the spouse's employment; unpaid leave of absence or a change from full-time to part-time status or vice versa of the employee or spouse; a substantial premium increase or other related status events that may be provided by applicable law. Termination of employment by the employee is not a change in family status.

Dental and Vision Insurance – Coverage becomes effective on the date you sign the election form provided you elect coverage within 31 days from your date of hire.

VADD Insurance - Coverage becomes effective on the first day of the month following the date you sign the election form provided you elect coverage within 31 days from your date of hire.

Important! The Insurance providers require changes to be made within 31days of any qualifying event. For example, upon the birth or adoption of a child, the child must be added within 31 days of the child's birth or effective date of adoption or the child will not be covered until the next annual election.

Identification Cards

CIGNA Dental – You may obtain CIGNA identification cards from CIGNA or Charity Johnson. If services are obtained from an out-of-network provider, claims form are available from CIGNA Dental website at www.cigna.com

Dental Source Dental – Dental Source will mail identification cards to your home. www.densource.com

Vision Benefits of America – VBA will mail identification cards to your home. www.vba.com

LEVELS OF COVERAGE for VADD
Choose the level of coverage that best fits your needs... from $10,000 - $750,000
(Amounts in excess of $350,000 cannot exceed 10 times annual salary)

$ 10,000	$ 160,000	$ 310,000	$ 460,000	$ 610,000
20,000	170,000	320,000	470,000	620,000
30,000	180,000	330,000	480,000	630,000
40,000	190,000	340,000	490,000	640,000
50,000	200,000	350,000	500,000	650,000
60,000	210,000	360,000	510,000	660,000
70,000	220,000	370,000	520,000	670,000
80,000	230,000	380,000	530,000	680,000
90,000	240,000	390,000	540,000	690,000
100,000	250,000	400,000	550,000	700,000
110,000	260,000	410,000	560,000	710,000
120,000	270,000	420,000	570,000	720,000
130,000	280,000	430,000	580,000	730,000
140,000	290,000	440,000	590,000	740,000
150,000	300,000	450,000	600,000	750,000

BENEFICIARY DESIGNATION – VADD: For new enrollment only. DO NOT complete if we have a beneficiary designation on file.

Complete addresses are required

Primary Beneficiary(ies)	**Address**	**Relationship**

Contingent Beneficiary(ies)	**Address**	**Relationship**
Will receive benefits in case person (s) listed above are deceased		

I hereby designate the above beneficiary(ies) and reserve the right to change my beneficiary(ies) at anytime without the consent of the named beneficiary(ies).

SIGNATURE_____ **DATE**: _____

(Full Legal Name)

Suggested Beneficiary Designations – May be used for primary and/or contingent. Note: A married woman should be designated by her own name not Mrs. Joe Doe

- One beneficiary – Mary E. Doe, wife
- Two beneficiaries (equal amounts) – John H. and Mary E. Doe, Parents, equally or survivor
- Three or more beneficiaries (equal amounts) – John H. and Mary E. Doe, Parents, and Joan J. Doe, sister, equally or survivor
- Unequal amounts – 75% to Mary E. Doe, wife, if living, otherwise to Jane J. Doe, mother; 25% to Jane J. Doe, mother, if living, otherwise to Mary E. Doe, wife
- To name your estate as beneficiary – write "Estate