



BENEFITS ENROLLMENT/TERMINATION/CHANGE FORM

EMPLOYEE INFORMATION: Please complete all information and place an (x) in the appropriate boxes below

NAME:	Last	First	M.I.	<input type="checkbox"/> MALE	<input type="checkbox"/> SINGLE
				<input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED
ADDRESS:	Street	City	State	Zip	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE	DATE OF HIRE	WORK PHONE	
AVERAGE HOURS WORKED PER WEEK	OCCUPATION		ANNUAL SALARY		

ENROLLMENT/CHANGE: All changes due to change in life status must be made within **30 days** of the event

<input type="checkbox"/> NEW HIRE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> STATUS CHANGE <input type="checkbox"/> COBRA	ADDITION <input type="checkbox"/> Add Self <input type="checkbox"/> Add Dependent	CANCELLATION <input type="checkbox"/> Cancel Self <input type="checkbox"/> Cancel Dependent	REASON FOR CHANGE <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Change in Dependent Status	<input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Other Insurance <input type="checkbox"/> Court Ordered Coverage <input type="checkbox"/> Other	GENERAL CHANGE <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Beneficiary Change
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EFFECTIVE DATE:

INSURANCE COVERAGE ELECTIONS: Available for full-time employees only (working 20 or more hours a week)

MEDICAL (Primary Care Physician election required for Direct HMO plan)			DENTAL (Primary Care Dentist election required for DMO plan)		VISION
**Empire Direct HMO <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Family **Primary Care Physician (PCP) ID Number	Empire HSA <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Family	Emblem EPO <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage	**Guardian DMO <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family **Primary Care Dentist (PCD) ID Number	Guardian PPO <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage	Blue View Vision <input type="checkbox"/> Employee Only <input type="checkbox"/> Family <input type="checkbox"/> Waive Coverage

SUPPLEMENTAL LIFE INSURANCE (Deductions for this benefit are taken on an after tax basis)

\$50,000
 \$100,000
 \$150,000
 \$200,000
 Waive coverage

MAXIMUM BENEFIT: \$200,000

Molloy College provides Employees with a Basic Term Life insurance benefit equal to the higher of \$50,000 or one times your basic annual earnings, up to a maximum of \$200,000 at no cost to you.

DEPENDENT LIFE INSURANCE (Deductions for this benefit are taken on an after tax basis. You must be enrolled in the Supplemental Life Insurance Plan to purchase Dependent Life)

Spouse: 50% of the Employee Supplemental Life amount, up to a maximum of \$100,000

Child(ren): Choice of \$500 or 10% of the Employee Supplemental Life amount, up to a maximum of \$10,000

INSURANCE BENEFICIARY DESIGNATION FOR BASIC LIFE, VOLUNTARY LIFE & LONG TERM DISABILITY (Percentage Payable Must Not Exceed 100% - You **MUST** list at least one primary beneficiary)

Primary Beneficiary Name (and address, if different from yours):	Percentage Payable:	Relationship:	SSN:
Secondary Beneficiary Name (and address, if different from yours):	Percentage Payable:	Relationship:	SSN:
**Contingent Beneficiary Name (and address, if different from yours):	Percentage Payable:	Relationship:	SSN:

**In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit

DEPENDENT INFORMATION: Attach sheet to list additional dependents

Check One Action	Check ALL that Apply	Relationship (Spouse or Child)	Last Name, First Name	FT Student	Gender	**Empire PCP ID No.	**Guardian PCD ID No.	Date of Birth	Social Security No.
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE <input type="checkbox"/> CHANGE	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE <input type="checkbox"/> CHANGE	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE <input type="checkbox"/> CHANGE	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE <input type="checkbox"/> CHANGE	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				

By signing this form, I hereby certify that all the information provided is true and correct. I understand that my Medical, Dental and Vision contributions will be deducted from my paycheck on a pre-tax basis until I specify otherwise, in writing. I further understand that coverage will become effective only on the date specified by Molloy College and/or the insurer after it has been approved by Molloy College and/or the insurer and full premium has been paid. I understand that the contributions for my coverage are subject to change, at the discretion of Molloy College and I can cancel my coverage, in writing, during an annual enrollment or special enrollment period.

Signature

Date

RETURN COMPLETED FORM TO HUMAN RESOURCES