Molloy College

BENEFITS ENROLLMENT/TERMINATION/CHANGE FORM

PLEASE PRINT & COMPLETE ALL REQUESTED INFORMATION

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

NAME: Last	First	M.I.	☐MALE ☐FEMALE	☐SINGLE ☐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

☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ STATUS CHANGE ☐ COBRA	**ADDITION** ☐ Add Self ☐ Add Dependent	**CANCELLATION** ☐ Cancel Self ☐ Cancel Dependent	**REASON FOR CHANGE*** Proof required for Change ☐ Marriage ☐ Birth/Adoption ☐ Change in Dependent Status ☐ Divorce/Legal Separation ☐ Other Insurance ☐ Court Ordered Coverage ☐ Other	**GENERAL CHANGE** ☐ Name Change ☐ Address Change ☐ Beneficiary Change

EFFECTIVE DATE:

INSURANCE COVERAGE ELECTIONS: Available for full-time employees only (working 30 or more hours a week)

MEDICAL

Empire EPO
- ☐ Employee Only
- ☐ Employee + One
- ☐ Family
- ☐ Waive Coverage

Emblem EPO
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family
- ☐ Waive Coverage

DENTAL (Primary Care Dentist election required for DHMO plan)

****Cigna DHMO**
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family
- ☐ Waive Coverage

****PCD ID No. & Name REQUIRED**

Cigna DPPO
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family
- ☐ Waive Coverage

VISION

Blue View Vision
- ☐ Employee Only
- ☐ Family
- ☐ Waive Coverage

****Copy of Marriage license is required for Family or Employee plus one coverage**

Enrollment cannot be processed unless PCD is elected

Check One Action	Check ALL that Apply	Relationship (Spouse or Child)	Last Name, First Name	Date of Birth	Gender	****Primary Care Dentist ID No.**	Social Security No.
☐ ADD ☐ REMOVE ☐ CHANGE	☐ MEDICAL ☐ DENTAL ☐ VISION				☐ M ☐ F		
☐ ADD ☐ REMOVE ☐ CHANGE	☐ MEDICAL ☐ DENTAL ☐ VISION				☐ M ☐ F		
☐ ADD ☐ REMOVE ☐ CHANGE	☐ MEDICAL ☐ DENTAL ☐ VISION				☐ M ☐ F		
☐ ADD ☐ REMOVE ☐ CHANGE	☐ MEDICAL ☐ DENTAL ☐ VISION				☐ M ☐ F		

INSURANCE BENEFICIARY DESIGNATION FOR MOLLOY SPONSORED LIFE INSURANCE PLAN - Must work 30 or more Hours to be eligible. (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

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. I also understand that it is my responsibility to apply for the Molloy College pension plan after one year of employment and attaining age 26.

X

Signature Date

DATE RECEIVED BY _____

RETURN COMPLETED FORM TO HUMAN RESOURCES

DATE ENTERED_____