



**BENEFIT OPEN ENROLLMENT FORM FOR 26 PAY EMPLOYEES**

**Section 1: Employee Information**

Name: \_\_\_\_\_ Employee ID Number: \_\_\_\_\_  
 Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender (circle one): M F  
 Campus Phone: (\_\_\_\_) \_\_\_\_\_ Department: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 E-mail: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Section 2: Dependent Information**

Please complete the following dependent information. If there are any additions or changes in your family status, please inform the Office of Human Resources in order to update our files. Please add a separate sheet for any additional dependents.

Name (Last, First)	Date of Birth (mm/dd/yyyy)	Gender (M/F)	Social Security Number	Full Time student (Yes/No)	Medical Coverage (Yes/No)	Dental Coverage (Yes/No)	Vision Coverage (Yes/No)
Spouse:							
Dependent:							
Dependent:							

**Section 3: Group Life Insurance**

This designation applies to Life with AD&D Insurance available through your employer. Complete this section to make changes for 2009/2010. Please check the **NO CHANGE** box if you do not wish to change your previous beneficiaries.  **NO CHANGE** to previous beneficiaries

**Primary Beneficiary(ies)**

Name*	Relationship to Employee*	Percent of Primary Benefit* =100%	Date of Birth* (mm/dd/yyyy)	Sex M/F	Social Security Number
		%			
		%			

\* Required Information

• Your designation revokes all prior designations

**Contingent Beneficiary(ies)** - These beneficiaries will be used in case there are no living primary beneficiaries at the time of the claim.

Name*	Relationship to Employee*	Percent of Primary Benefit*=100%	Date of Birth* (mm/dd/yyyy)	Sex M/F	Social Security Number
		%			
		%			

**Section 4: Additional Life Insurance**

Complete this section to make changes for 2009/2010. Please check the **NO CHANGES** box if you want to keep your current coverage the same in 2009/2010.

- I wish to enroll in Additional Life Insurance coverage
- I wish to change coverage amount
- NO CHANGE** to my current plan
- CANCEL** my current coverage
- I do not elect Additional Life coverage

Have any tobacco products been used in the last 12 months?  
 You:  Yes  No Your spouse:  Yes  No

Amount of coverage selected for:

**Life:** You: \$ \_\_\_\_\_ **Life:** Your Spouse: \$ \_\_\_\_\_ **Life:** Your Child: \$ \_\_\_\_\_  
**AD&D:** You: \$ \_\_\_\_\_ **AD&D:** Your spouse: \$ \_\_\_\_\_ **AD&D:** Your Child: \$ \_\_\_\_\_

**Section 5: Disability**

- Short Term Disability coverage is automatically provided at no cost to you. Under Short Term Disability, a disabled employee would receive 66 2/3 % salary up to a maximum benefit of \$2,000 per week for a maximum of 11 weeks.
- Core Long Term Disability coverage is automatically provided at no cost to you. This plan provides a benefit of 60% salary up to a maximum of \$2,000 per month.
- Long Term Disability Buy-Up coverage is available and is purchased by the employee through payroll deduction. This plan provides a benefit of 66 2/3% salary up to a maximum of \$14,000 per month.

Please complete this section to enroll in Long Term Disability Buy-Up coverage. Long Term Disability Buy-Up coverage is at the cost of the employee.

- I wish to enroll in the Long Term Disability Buy-Up coverage. The per pay period deduction premium will be calculated by UNUM.
- I do not elect Long Term Disability Buy-Up coverage.

**Section 6: Medical Plan Options**

Complete this section to make medical plan changes for 2009/2010 Plan Year. Please check the **CONTINUE** box if you want to keep your current coverage the same in 2009/2010. Check all changes that apply.

- CONTINUE** my current Medical tier selection in the 2009/2010 Plan Year
- CANCEL** my current Medical Insurance Coverage
- BEGIN** my Medical Insurance coverage (Selection required below)
- Change** my current Medical tier selection coverage. My new selection is indicated below. Additions or deletions in family members covered must be listed in section 2 "Dependent Information".
- I do not elect Medical coverage

*~ 4 Plan Choices Offered. Select only one.*

**PPO 80/20% Coinsurance Plan without HRA**

(In Network Plan Year Deductible:  
Individual - \$300; Family - \$900)

			HRA
Employee	_____	\$ 96.37 (S1)	\$0
Employee + Child(ren)	_____	\$ 173.63 (S2)	\$0
Employee + Spouse	_____	\$192.88 (S3)	\$0
Family	_____	\$ 270.00 (S4)	\$0

**PPO 70/30% Coinsurance Plan with HRA**

(In Network Plan Year Deductible:  
Individual - \$500; Family - \$1500)

			HRA*
Employee	_____	\$ 55.85 (B1)	\$60
Employee + Child(ren)	_____	\$ 100.62 (B2)	\$120
Employee + Spouse	_____	\$ 111.81 (B3)	\$120
Family	_____	\$ 156.46 (B4)	\$120

**Risk/Reward 80/20% Coinsurance with HRA**

(In Network Plan Year Deductible:  
Individual - \$1500; Family - \$4,500)

			HRA*
Employee	_____	\$ 44.31 (R1)	\$100
Employee + Child(ren)	_____	\$ 79.73 (R2)	\$200
Employee + Spouse	_____	\$ 88.50 (R3)	\$200
Family	_____	\$ 123.92 (R4)	\$200

**Blue Options 80/20% Coinsurance with HRA**

(In Network Plan Year Deductible:  
Individual - \$1,500; Family - \$4,500)

			HRA*
Employee	_____	\$ 41.65 (P1)	\$100
Employee + Child(ren)	_____	\$ 75.00 (P2)	\$200
Employee + Spouse	_____	\$ 83.31 (P3)	\$200
Family	_____	\$116.65 (P4)	\$200

\* HRA fund balances roll over to the next plan year and are vested after 36 months of continuous participation in the HRA.

\* HRA funds are available by using your ICUBA Benefits Card.

**Default Election:** If no election is made above, your coverage will default to the same plan & tier of coverage as the prior plan year.

**Section 7: Flexible Spending Account**

**Re-enrollment is required each year in order to continue participation.**

- Enroll in a **Medical Flexible Spending Account (MFSA\*)** \$.....  
(Maximum is \$5,000 per employee. Show the annual amount, NOT the per paycheck amount.)
- Enroll in a **Dependent Care Flexible Spending Account (DCFSA\*)** \$.....  
(Maximum is \$5,000 including any pledge made by a spouse, if filing jointly.)
- I do not elect Flexible Spending Account

I understand that my salary will be reduced in equal amounts based on my number of annual (or contracted) scheduled pay events. **I understand that any amount not expensed by the end of the Plan Year will be forfeited (lost).** I may submit claims for reimbursement for up to 90 days following the close of the Plan Year. Those claims must be eligible expenses incurred and provided during the appropriate Plan Year.

**Failure to re-elect MFSA and DCFSA will result in discontinuation of Flexible Spending Account at the end of each Plan Year.**

\* MFSA and DCFSA funds are available by using your ICUBA benefits card.

**Section 8: Vision Insurance Options**

Complete this section to make Vision Plan changes for 2009/2010. Check all changes that apply.

- CONTINUE** my current Vision Insurance Coverage ( Employee only, Family)
- CANCEL** my current Vision Insurance Coverage
- BEGIN** my Vision Insurance Coverage
- Change** my current Vision Insurance Coverage. My new selection is indicated below. Additions or deletions in family members covered must be listed in section 2 "Dependent Information".
- I do not elect Vision coverage

Employee	_____	\$2.00	(V1)
Family	_____	\$5.11	(V2)

**Default Election:** Please note that **Employee +1** is no longer available. Coverage under this tier will automatically default to family coverage unless you make an alternate election.

## Section 9: Dental Insurance Options

Complete this section to make Dental Plan changes for 2009/2010. Check all changes that apply.

- CANCEL my current Dental Insurance Coverage
- BEGIN my Dental Insurance Coverage
- Change my current Dental Insurance Coverage. My new selection is indicated below. Additions or deletions in family members covered must be listed in section 2 "Dependent Information".
- I do not elect Dental coverage

### HUMANA (DF)

Managed Care CS-250 Plan:  
w/ orthodontia benefits

Employee	_____	\$4.60	(P1)
Employee + 1	_____	\$9.22	(P2)
Family	_____	\$14.31	(P3)

### HUMANA (DLS)

PPO Low Plan  
w/orthodontia benefits:

Employee	_____	\$14.95	(D1)
Employee + 1	_____	\$29.77	(D2)
Family	_____	\$50.08	(D4)

Facility # for CS250 Plan: \_\_\_\_\_ (SEE Dental Enrollment Booklet )

### HUMANA (TBD)

PPO High Plan

w/orthodontia benefits:

Employee	_____	\$16.83
Employee + 1	_____	\$33.53
Family	_____	\$56.39

**Default Election:** If no election is made above, employees currently participating in the DMO (Managed Care CS-150) coverage will default to DMO (CS-250) coverage at the same tier level as the previous year. Those employees, currently participating in the PPO 720 will default to the PPO Low Plan at the same tier level as the previous year.

## Section 10: AFLAC

AFLAC ~ 3 Plans Offered. May select any combination of plans offered.

- CANCEL my current AFLAC Coverage
- CONTINUE my current AFLAC Coverage
- BEGIN my AFLAC coverage. (Enrollment form required.)
- I do not elect AFLAC Coverage

### ACCIDENT Plan: (AFA)

Employee	_____	\$ 7.89	(A1)
Employee + Spouse	_____	\$11.22	(A2)
One Parent Family	_____	\$13.11	(A3)
Two Parent Family	_____	\$16.62	(A4)

### CANCER Plan: (AFC)

Employee	_____	\$17.31	(C1)
Employee + Spouse	_____	\$29.72	(C2)
One Parent Family	_____	\$21.32	(C3)
Family	_____	\$29.72	(C4)

### SICKNESS Plan: (AFS)

**If your age is 18-39:**

Employee	_____	\$11.35	(S1)
Employee + Spouse	_____	\$21.23	(S2)
One Parent Family	_____	\$19.25	(S3)
Two Parent Family	_____	\$22.75	(S4)

**If your age is 40-49:**

Employee	_____	\$12.18	(S5)
Employee + Spouse	_____	\$21.83	(S6)
One Parent Family	_____	\$19.67	(S7)
Two Parent Family	_____	\$23.90	(S8)

**If your age is 50-59:**

Employee	_____	\$15.23	(T1)
Employee + Spouse	_____	\$27.41	(T2)
One Parent Family	_____	\$22.38	(T3)
Two Parent Family	_____	\$29.45	(T4)

**If your age is 60-70:**

Employee	_____	\$22.06	(T5)
Employee + Spouse	_____	\$38.68	(T6)
One Parent Family	_____	\$28.07	(T7)
Two Parent Family	_____	\$39.16	(T8)

**Default Election:** If no election is made above, your coverage will default to the same plan & tier of coverage as the prior plan year.

## Section 11: Long Term Care Benefit

Complete this section to make changes for 2009/2010. Please check the **CONTINUE** box if you wish to keep your current coverage the same in 2009/2010.

- CONTINUE** my current coverage
- CANCEL** my current coverage
- I wish to enroll in Long Term Care Insurance coverage.
- CHANGE** my coverage amount
- I do not elect Long Term Care coverage

Do you want to add the Total Home Care option?  Yes  No

- Duration of benefits may vary depending on where benefits are received

<input type="checkbox"/> <b>Plan A</b>	<input type="checkbox"/> <b>Plan B</b>	<input type="checkbox"/> <b>Plan C</b>
<ul style="list-style-type: none"><li>• Long Term Care Facility / \$1000 Monthly Benefit</li><li>• Simple Inflation</li></ul>	<ul style="list-style-type: none"><li>• Long Term Care Facility / \$2500 Monthly Benefit</li><li>• Simple Inflation</li><li>• 4 Years Benefit Duration*</li></ul>	<ul style="list-style-type: none"><li>• Long Term Care Facility / \$2500 Monthly Benefit</li><li>• Simple Inflation</li><li>• 6 Years Benefit Duration*</li></ul>

## Section 12: Prepaid Legal Services

Complete this section to make changes for 2009/2010. Please check the **NO CHANGE** box if you want to keep your current coverage the same in 2009/2010.

- NO CHANGE** to my current plan
- CANCEL** my current prepaid Legal Services
- I wish to enroll in **FAMILY LEGAL PLAN** only
- I wish to enroll in **IDENTITY THEFT PLAN** only
- I wish to enroll in both **FAMILY LEGAL PLAN** and **IDENTITY THEFT**

**Default Election:** If no election is made above, your coverage will default to the same plan & tier of coverage as the prior plan year.

## Employee Authorization /Certification

1. I understand that I am enrolling in the Florida Tech Flexible (Pre-Tax) Benefits selected on this form. Participation requires completion of an enrollment form for each new benefit selected. I may change or cancel my selections during the Annual Open Enrollment period established by Florida Tech. Such elections become effective on the first day of the next Plan Year. During the Plan Year, I may not change my elections unless I experience a qualifying family status change as defined by the IRS. I understand payroll deductions will be taken before my income is taxed for Federal, applicable State, Social Security, and Medicare purposes, as allowed by law. Payroll deductions will be calculated based on 26 scheduled pay events.

2. Long Term Care and Prepaid Legal services are deducted on a post-tax basis. I may change or cancel my selections at any time during the Plan Year for these benefits only.

3. I understand that my elected Medical, Dental, Vision, AFLAC, Long Term Care, Short Term Disability and Long Term Disability, Additional Life Insurance, and Prepaid Legal Services benefits will remain in force for the future plan years as long as the same benefit plan continues to be offered by the same insurance carrier.

**PLEASE NOTE** For individuals who **do not** make an active election for certain benefits for the Plan Year commencing April 1, 2009, the following **DEFAULT ELECTIONS** will occur:

- **MEDICAL PLAN (BCBS)** – your coverage will default to the same plan & tier of coverage as the prior plan year.
- **FSA Accounts** – if no active election is made for the new plan year, your participation in the FSA will end.
- **DENTAL PLAN (Humana)** – Those individuals currently participating in the DMO who do not execute an active election for the new Plan Year, will default to DMO coverage at the same tier level as the previous year. Those individuals who currently participate in PPO 720 will default to the PPO Low plan at the same tier level as the previous year.
- **VISION PLAN (Advantica)** – Individuals currently participating in the Vision Plan with employee only coverage, who do not make an active election for the new Plan Year, will default to employee only coverage in the new vision plan. Individuals currently participating in the vision plan with tier levels employee+1 or family coverage, who do not make an active election for the new Plan Year, will default to family coverage in the new Vision Plan.

4. I have read and understand the University's plan eligibility requirements; the dependents listed on this form meet all eligibility requirements. I understand my duty to notify the University **within 30 days of any changes** that affect my eligibility or any of my covered dependents; for example, marriage or divorce.

5. I understand that the plan may use my personal health information for the purposes of treatment, payment, and health care operations, and other uses as outlined in the plan's privacy notice, and consistent with HIPAA regulations.

6. The information supplied on this form is true and complete to the best of my knowledge.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_