ROGER WILLIAMS UNIVERSITY – ADJUNCT FACULTY

Benefit Election and Waiver Form

❑ New Enrollment / Waiver ❑ Employment Status Change ❑ Open Enrollment ❑ Cancellation of Benefits

Qualifying Event Date: _____ / _____ / _____ ❑ Loss of Coverage ❑ Family Status Change

Section A – Employee Information

Name: _____ RWU ID: _____
(Last, First, Middle Initial)

Department: _____ Date of Employment: _____

Position: _____ Date of Benefit Eligibility: _____
(1st of the month following date of FT employment or qualifying event)

Section B – Medical and/or Dental Election

MEDICAL

Blue Cross Blue Shield of Rhode Island - Includes Health Reimbursement Account (HRA) Coverage

Please select one of the following coverage levels:

PLAN A (BlueCHiP Flex) ❑ Individual ❑ Family

PLAN B (HealthMate Coast-to-Coast) ❑ Individual ❑ Family

PLAN C (Blue Choice) ❑ Individual ❑ Family

DENTAL

Delta Dental of Rhode Island ❑ Individual ❑ Family

Please select one of the following coverage levels:

***** PLEASE READ & SIGN PAGE 2 *****

Section C - Payroll Authorization

1. I understand that my employer or plan sponsor, in accordance with the underwriting guidelines of the carrier, will determine the effective date and termination date of my benefits.

2. I understand that my employee contributions for the benefits I elect are payroll deducted. I authorize the deductions from my paycheck for any benefits plans in which I enroll and understand that the University will deduct any retroactive contributions, as needed.

3. I understand that I am responsible for any benefit deductions. If deductions are not collected through payroll because I did not receive a paycheck, I understand that I must coordinate such payment(s) with the Department of Human Resources.

4. I have the option of changing my elections only during the University's annual open enrollment or within 30 days of a documented qualified family status change.

5. I am in receipt of information on voluntary benefits.

6. I understand that eligibility to enroll at a later date shall be at the start of each new semester upon verification of eligible contact hours.

7. I understand that my payroll deductions for benefit elections are **pre-tax**, where applicable. If you would like to have the applicable benefit deductions taken **post-tax**, please submit your request in writing to the Department of Human Resources.

8. I understand that if I elect to cover a domestic partner, certain premiums may not be pre-tax and that the University portion of the premium may be considered taxable income.

By signing below, I certify that I have read and understand the above statements and that all information is true and correct to the best of my knowledge.

_____ _____

Employee Signature Date

For Human Resources Use Only: **Contact Hours:** ❑6 ❑ 9

Benefit Plan	Deduction Code	Amount	Adjustment Code	Amount
Medical:		$	MDAJ	$
Dental:		$	DDAJ	$
Basic Life Insurance / AD&D:	/			
Optional Life - Employee:	VLFE	$	VIAD	$
Optional AD&D - Employee:	VADE	$	VIAD	$
Optional Life - Spouse:	VLFS	$	VIAD	$
Optional AD&D - Spouse:	VADS	$	VIAD	$
Optional Life - Child:	VLFC	$	VIAD	$
Optional AD&D - Child:	VADC	$	VIAD	$
403(b) SRA:		$		$
*Other:*_____		$		$
*Other:*_____		$		$