

**ROGER WILLIAMS UNIVERSITY**

Benefit Election and Waiver Form

**ADJUNCT FACULTY**

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: \_\_\_\_\_

**Medical 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 Election**

**DENTAL**

**Delta Dental of Rhode Island**

Individual    Family

Please select one of the following coverage levels:

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

**Payroll Authorization - Please Read & Sign**

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