ROGER WILLIAMS UNIVERSITY and SCHOOL OF LAW

Benefit Election and Waiver Form

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

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

Section A – Employee Information

Name: ______________________________ **RWU ID:** ______________
(First, Middle Initial, Last)

Department: ______________________________ **Date of FT Employment:** ______________

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

Classification: ❑ Facilities ❑ Faculty ❑ Non-Aligned
Check one (required): ❑ PSSA ❑ Public Safety ❑ School of Law

Section B – BENEFIT COVERAGE ELECTIONS

MEDICAL – Blue Cross Blue Shield of Rhode Island*

Please select your plan and coverage level:

PLAN A (BlueCHiP Flex) ❑ Individual ❑ Family
PLAN B (HealthMate Coast-to-Coast) ❑ Individual ❑ Family
PLAN C (Blue Choice) ❑ Individual ❑ Family

*Includes Health Reimbursement Account (HRA) Coverage

DENTAL - Delta Dental of Rhode Island

Please select your coverage level: ❑Individual ❑ Family

WAIVER of Coverage(s)

WAIVER of MEDICAL and DENTAL COVERAGE

(For Facilities, Non-Aligned, PSSA, Public Safety, and School of Law employees)

**To be eligible for and receive buyback, you must waive BOTH medical and dental coverage.*

Buyback – Medical and Dental* ❑ Individual ❑ Family

WAIVER of MEDICAL and/or DENTAL COVERAGE

(For University FACULTY members only)

Please select one of the following coverage levels: Buyback - Medical ❑ Individual ❑ Family
Please select one of the following coverage levels: Buyback - Dental ❑ Individual ❑ Family

Vision Coverage

Vision - VSP Eastern Vision Service Plan **Choose your plan:** Base Premium

Please select one of the following coverage levels:

Individual **Employee Plus One** **Employee & Children** **Family**

Optional Coverages

Optional Coverages - Please select the coverages in which you would like to enroll. HR will provide the appropriate enrollment forms/instructions/costs for Optional Life Insurance. For other coverages, instructions will be provided by the insurance company.

Optional Life and AD&D - Lincoln Financial

Employee

Spouse - *requires Employee plan of equal or greater value*

Children - *requires Employee plan*

Supplemental Disability - The Standard

Long Term Care - Genworth*

**Genworth will directly bill you for the premium*

Section C - Payroll Deduction 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 benefit coverage.
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 qualified family status change.
5. I am in receipt of information on voluntary benefits.
6. By opting out of medical and/or dental coverage, I attest that myself and any dependent I claim on my taxes have group medical and/or dental coverage. I understand that group medical coverage does not include coverage through the marketplace (also known as the Exchange) or coverage directly from an insurance company. I accept responsibility for myself and my dependents' medical and/or dental insurance, including confirming that the other coverage is minimal essential coverage as defined by the Affordable Health Care Act.
   I also understand that in making this election, my employer is not responsible for any lapse in insurance coverage through my spouse or other entity. Eligibility to enroll later shall be at the University's annual open enrollment or within 30 days of a qualified family status change.
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