ROGER WILLIAMS UNIVERSITY

Benefit Election and Waiver Form

ADJUNCT FACULTY

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

Benefit Start Date: 07/01/2026 ❑ Loss of Coverage ❑ Family Status Change

Benefit Start date is 2/1 for the Spring semester, 9/1 for the Fall semeser, 7/1 for Open Enrollment, or the 1st of the month after a qualifying event.

Section A – Employee Information

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

Department: _____ Date of Employment: _____

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
PLAN D (Blue Choice VALUE)	☐ Individual	☐ Family

Dental Election

DENTAL

Delta Dental of Rhode Island

Individual ☐ Family ☐

Please select one of the following coverage levels:

Cancel Coverages

Check below for each benefit you wish to cancel.

MEDICAL ☐ **DENTAL** ☐

***** 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