ROGER WILLIAMS UNIVERSITY
Employee Medical Plan Election and Payroll Authorization Form

Enrollment Offer Under the Affordable Health Care Act

Name (Last, First, Initial) :	SS#: (last four digits)
Date of Full Time Employment: / /	Date of Benefit Enrollment:
Department Name:	Position:

(Check One) ❑ Non-Aligned (Executives, Administrators, Professional Staff & Staff) ❑ School of Law ❑ University Faculty ❑ PSSA

MEDICAL Blue Cross Blue Shield HealthMate Coast to Coast with HRA

☐ Individual ☐ Family

(Check One) ❑ Dining ❑ Facilities ❑ Public Safety

MEDICAL with HRA (choose a plan)

☐ PLAN A - Blue Cross Blue Shield HealthMate Coast to Coast

☐ Individual ☐ Family

☐ PLAN B – Blue Cross Blue Shield Select RI

☐ Individual ☐ Family

***** PLEASE READ & SIGN ON REVERSE SIDE *****

1. I certify that all information is true and correct to the best of my knowledge.

2. I understand that the effective date and termination date of my benefits will be determined by my employer in accordance with the underwriting guidelines of the carrier and eligibility requirements under the Affordable Health Care Act.

3. 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.

4. If I am without a paycheck I am responsible for premiums due and understand that I must coordinate such payment(s) with the Office of Human Resources.

5. I elect to accept all pre-tax benefits available to me currently or in the future under the plans offered. I understand that in order to waive all pre-tax benefits I must initial here: ☐ (indicates waiver of pre-tax benefits)

I have read and understand the above statements. I authorize the deductions according to the election on this form.

_____ _____/_____/_____

Employee Signature Date