

## BENEFITS CHANGE FORM

Name: _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> <span>Last</span> <span>First</span> <span>M.I.</span> </div> Campus Address _____ Zip Code _____ Campus Phone _____	University ID Number _____  Email Address _____
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<b>1. ADMINISTRATIVE UNIT</b> <input type="checkbox"/> UNL <input type="checkbox"/> IANR <input type="checkbox"/> UNMC <input type="checkbox"/> UNO <input type="checkbox"/> UNK <input type="checkbox"/> UNCA	<b>2. PAY CYCLE</b> <input type="checkbox"/> BIWEEKLY <input type="checkbox"/> MONTHLY	<b>3. CHANGE IN STATUS (check one)</b> <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> DEPENDENT _____ / _____ / _____ <small>month      day      year</small> Reason for change: _____
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<b>4. EFFECTIVE DATE</b> _____ / _____ / _____ <small>month      day      year</small>	<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; width: 60%;">7. NUFLEX CHOICES</th> <th style="text-align: center; width: 15%;">Option Number</th> <th style="text-align: center; width: 25%;">Coverage Category</th> </tr> <tr> <td>Medical</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Dental</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Vision</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Long Term Disability</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Life Insurance Employer-Provided (1x Annual Budgeted Salary*)</td> <td></td> <td></td> </tr> <tr> <td>Voluntary Life Insurance</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Accidental Death &amp; Dismemberment</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Dependent Life Insurance Spouse</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Dependent Life Insurance Child(ren)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Reimbursement Account Health Care</td> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">Total amount through December 31</td> </tr> <tr> <td>Dependent Day Care</td> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">Total amount through December 31</td> </tr> </table> <p style="font-size: small; margin-top: 10px;">*Up to a \$120,000 maximum.</p>	7. NUFLEX CHOICES	Option Number	Coverage Category	Medical	_____	_____	Dental	_____	_____	Vision	_____	_____	Long Term Disability	_____	_____	Life Insurance Employer-Provided (1x Annual Budgeted Salary*)			Voluntary Life Insurance	_____	_____	Accidental Death & Dismemberment	_____	_____	Dependent Life Insurance Spouse	_____	_____	Dependent Life Insurance Child(ren)	_____	_____	Reimbursement Account Health Care	\$ _____	Total amount through December 31	Dependent Day Care	\$ _____	Total amount through December 31
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<b>5. SPOUSE IS AN EMPLOYEE OF THE UNIVERSITY OF NEBRASKA</b>  Spouse's Name: _____  Spouse's Social Security Number: _____ - _____ - _____																																					
<b>6. TOBACCO/NICOTINE DESIGNATION CHANGE</b> <small>(for life insurance)</small>  Have you used any form of tobacco or nicotine, including nicotine substitutes (e.g. patches or gum) within the last 12 months?  <input type="checkbox"/> Yes <input type="checkbox"/> No    If No, complete the following:  Date quit using tobacco/nicotine _____ / _____ / _____ <b>OR</b> <input type="checkbox"/> Never Used <small>month      day      year</small>																																					

**8. EMPLOYEE SIGNATURE**

I understand and approve the enrollment as indicated above. In accordance with Nebraska Revised Statute §48-1230 (Reissue 1984), I hereby authorize the Board of Regents of the University of Nebraska (Employer) to deduct from my earnings the amount of my premiums or other contributions (if any) for the benefit options noted in Section 7 above.

I understand that I will not pay income tax or FICA tax on my medical, dental, vision, long term disability, and AD&D insurance premiums, or Reimbursement Account contributions. Life insurance that exceeds \$50,000 may be subject to imputed income. However, my gross salary before these deductions will be used to figure salary increases or pay-related fringe benefits. Under IRS rules, I may not change my benefit elections (Section 7 above) during the calendar year unless I experience a qualified change in status. (Health Care Reimbursement Account elections may not be reduced during the calendar year.)

Each year, during the annual enrollment period, I will have the option to change certain coverages whether or not I have had a qualified change in status event during the calendar year (some benefits may have certain enrollment restrictions). In the future, any application to add or increase coverage on me or any of my dependents may require proof of insurability for any person proposed for coverage. Any application must be submitted in accordance with university and/or insurance company guidelines.

If you are declining medical insurance enrollment for yourself or your dependents (including your spouse) because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth or adoption.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Any material misrepresentation made by me in the above "Tobacco/Nicotine Designation," including my tobacco/nicotine use history, may void the insurance, pursuant to the Incontestable Clause of the policy.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# BENEFITS CHANGE FORM INSTRUCTIONS

Use this Benefits Change Form to add, delete or change your University of Nebraska benefits. Contact your Campus Benefits Office for additional information or questions regarding benefit coverage and costs.

You are eligible for university provided benefits under the NUFlex program if you are employed in a "Regular position" with an FTE of .5 or greater or employed in a "Temporary position" for more than 6 months with an FTE of .5 or greater.

**Review your benefits materials carefully. Complete the "Option Number" and "Coverage Category" choices and any Reimbursement Account contributions in Section 7.**

If you elect not to have coverage in one or more benefit plans, or if you wish to increase or add insurance coverage for you or any dependent(s) in the future, you and/or any dependent(s) proposed for coverage may need to satisfy proof of insurability as required by the insurance company.

Under the current tax law, your benefit selections are in force for the balance of the calendar year. You may make changes only if you experience a qualified change in status. Any application for changes and/or additions of coverage must be submitted in a timely fashion in accordance with insurance company and university guidelines. As a general rule, any applications for eligible coverage changes must be received within 31 days of the qualified change in status event.

Except for long term care, voluntary life insurance, and dependent life insurance, your payroll deductions for university provided benefits are **salary reductions**. This means that you will not pay federal or state income tax or Social Security tax on the cost of these benefits. Because your premiums for these benefits are tax-exempt, you save on taxes which reduces the net cost to you.

Please print clearly. Begin by filling in your name (last name first), Campus Address, Campus Phone Number, University ID Number and Email Address.

1. **Administrative Unit:** Check the administrative unit to which you report. This is not always the same as the campus on which you are located. Check **UNL** (University of Nebraska-Lincoln), **IANR** (Institute of Agriculture and Natural Resources), **UNMC** (University of Nebraska Medical Center), **UNO** (University of Nebraska at Omaha), **UNK** (University of Nebraska at Kearney), or **UNCA** (Central Administration and Computing Services).
2. **Pay Cycle:** Check **One-biweekly** if you are paid every two weeks, **monthly** if you are paid monthly.
3. **Change in Status:** Check whether your request to change benefits is due to an employee or dependent change and write in the date of the status change (date of marriage, divorce, job change, etc.). Indicate the reason for the status change, i.e. marriage, job change, etc. Note: Attach documentation to support the status change.
4. **Effective Date:** Indicate the date your benefits are to begin. This will be the first of the month following the date of the benefit change.
5. **Spouse Employment:** Check **only** if your spouse is currently employed by the University of Nebraska. Include your spouse's **name** and **Social Security Number** in the spaces provided. If your spouse is employed by the university, the cost of your benefits may be reduced by contributions from your spouse's department. Contact your Campus Benefits Office for more information.
6. **Tobacco/Nicotine Designation Change:** Complete the Tobacco/Nicotine Designation if you are changing your current tobacco/nicotine designation. Indicate Yes (have used tobacco or nicotine within the last 12 months) or No (have not used any form of tobacco or nicotine within the last 12 months). If you indicated No, include the date you quit using tobacco/nicotine; or if you have never used tobacco/nicotine, indicate "never used."
7. **NUFlex Choices:** Complete the appropriate Option Numbers and Coverage Category. The corresponding price tags for these selections are shown on the NUFlex Price Tag Summary. For Reimbursement Account salary reductions, enter the total annual amount you want deducted through December 31. Health Care Reimbursement Account elections may not be reduced during the calendar year.

## SIGNATURE REQUIREMENTS

8. **Employee Signature:** The application must be signed by you.