

BENEFITS ENROLLMENT FORM

Name: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Last First M.I. </div>	_____ - ____ - ____ Social Security Number
Campus Address _____ Zip Code _____ Campus Phone _____	Personnel Number _____ Email Address _____

1. ADMINISTRATIVE UNIT <input type="checkbox"/> UNL <input type="checkbox"/> IANR <input type="checkbox"/> UNMC <input type="checkbox"/> UNO <input type="checkbox"/> UNK <input type="checkbox"/> UNCA	2. PAY CYCLE <input type="checkbox"/> BIWEEKLY <input type="checkbox"/> MONTHLY	3. DATE OF HIRE/ELIGIBILITY ____ / ____ / ____ <small style="display: flex; justify-content: space-around; width: 80%; margin: 0 auto;"> month day year </small>	4. DATE OF BIRTH ____ / ____ / ____ <small style="display: flex; justify-content: space-around; width: 80%; margin: 0 auto;"> month day year </small>
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5. EFFECTIVE DATE ____ / ____ / ____ <small style="display: flex; justify-content: space-around; width: 80%; margin: 0 auto;"> month day year </small>	<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 60%;">8. NUFLEX CHOICES</th> <th style="width: 20%;">Option Number</th> <th style="width: 20%;">Coverage Category</th> </tr> <tr> <td>Medical</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Dental</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Vision</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Long Term Disability</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Life Insurance</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Accidental Death & Dismemberment</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Dependent Life Insurance Spouse</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Dependent Life Insurance Child(ren)</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Reimbursement Account Health Care</td> <td>\$ _____</td> <td>Total amount through December 31</td> </tr> <tr> <td>Dependent Care</td> <td>\$ _____</td> <td>Total amount through December 31</td> </tr> </table>	8. NUFLEX CHOICES	Option Number	Coverage Category	Medical	_____	_____	Dental	_____	_____	Vision	_____	_____	Long Term Disability	_____	_____	Life Insurance	_____	_____	Accidental Death & Dismemberment	_____	_____	Dependent Life Insurance Spouse	_____	_____	Dependent Life Insurance Child(ren)	_____	_____	Reimbursement Account Health Care	\$ _____	Total amount through December 31	Dependent Care	\$ _____	Total amount through December 31
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6. SPOUSE IS AN EMPLOYEE OF THE UNIVERSITY OF NEBRASKA Spouse's Name: _____ Spouse's Social Security Number: _____ - ____ - ____																																		
7. TOBACCO/NICOTINE DESIGNATION <small>(for life insurance enrollment)</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 ____ / ____ / ____ OR <input type="checkbox"/> Never Used																																		

9. PRIMARY BENEFICIARY NAME: _____	RELATIONSHIP: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
SECONDARY BENEFICIARY NAME: _____	RELATIONSHIP: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	

10. 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 8 above.

I understand that I will not pay income tax or FICA tax on my medical, dental, vision, long term disability, life (amounts up to \$50,000), and ad&d insurance premiums, or Reimbursement Account contributions. 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 8 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 smoking/nicotine use history, may void the insurance, pursuant to the Incontestable Clause of the policy.

EMPLOYEE SIGNATURE _____ DATE _____

BENEFITS ENROLLMENT FORM INSTRUCTIONS

Use this Benefits Enrollment Form to enroll for your University of Nebraska benefits. NUFlex offers you a variety of benefit and insurance options that are explained in detail in your enrollment materials. 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 benefit materials carefully. Complete the "Option Number" and "Coverage Category" choices and any Reimbursement Account contributions in Section 8.

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. New employees may apply for any medical option. No medical option changes, however, will be permitted except during the annual NUFlex enrollment period.

Except for long term care, life insurance coverage exceeding \$50,000 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), Social Security Number, Campus Address, Personnel Number, Campus Phone 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 either **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. **Date of Hire/Eligibility:** If you are a new employee, fill in the date that your employment began at the university. If you are newly eligible for benefits, fill in the date in which you became eligible for benefits.
4. **Date of Birth:** Complete with your birth date.
5. **Effective Date:** Indicate the date your benefits are to begin. This will be the first of the month following your date of hire/eligibility. If the date of hire/eligibility is the first working day of the month, then coverage would begin on that date.
6. **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.
7. **Tobacco/Nicotine Designation:** The Tobacco/Nicotine Designation request only applies to the group life insurance benefit. 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."
8. **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 amount you want deducted through December 31.
9. **Primary and Secondary Beneficiary Names:** The Primary Beneficiary may be one or more persons (or a trust) you designate to receive life insurance death benefits should you die. The beneficiary must be "named" which requires you to provide the names of your children rather than requesting "My Children." Death benefits will be distributed equally to any surviving primary beneficiaries. If there are no surviving primary beneficiaries, death benefits will be provided to the secondary beneficiaries.

SIGNATURE REQUIREMENTS

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