2018 OPEN ENROLLMENT REQUEST FORM
REGULAR PART-TIME STAFF (30 or more hours per week)

YOU ARE CURRENTLY ENROLLED IN THE FOLLOWING BENEFITS:

Please select your calendar year (CY) 2018 benefit elections below. Open Enrollment Request Forms must be returned to the Office of Human Resources Development (HRD) by 4:30pm on Friday, November 10, 2017. All elections become effective January 1, 2018.

MEDICAL INSURANCE – United HealthCare

Confirm your plan election and coverage election:

☐ I do not wish to purchase

Select Medical Plan Premium Payment Method (if enrolling): ☐ Pre-tax bi-weekly payroll deduction ☐ Post-tax monthly direct billing

☐ NEW High Deductible-based Plan (HDBP) - with Health Savings Account (HSA)
  ☐ Employee only – University will contribute $1,200 (if annualized) into your HSA*.
  ☐ Employee + spouse – University will contribute $2,400 (if annualized) into your HSA*.
  ☐ Employee + child(ren) – University will contribute $2,400 (if annualized) into your HSA*.
  ☐ Employee + spouse + child(ren) – University will contribute $2,400 (if annualized) into your HSA*.

NOTE: Contributions into a Health Reimbursement Account (HRA) will be made in lieu of HSA enrollment ONLY for employees currently enrolled in Medicare Part A and/or B AND/OR those employees collecting social security income.

☐ I am currently enrolled in Medicare Part A and/or B ☐ I am currently collecting Social Security Income

*Participation in a pre-tax health savings account requires a Participation and Salary Reduction Agreement Form for enrollment for CY 2018. Annual IRS limits will apply.

☐ Deductible-based Plan (DBP) - with Health Savings Account (HSA)
  ☐ Employee only – University will contribute $750 (if annualized) into your HSA*.
  ☐ Employee + spouse – University will contribute $1,500 (if annualized) into your HSA*.
  ☐ Employee + child(ren) – University will contribute $1,500 (if annualized) into your HSA*.
  ☐ Employee + spouse + child(ren) – University will contribute $1,500 (if annualized) into your HSA*.

NOTE: Contributions into a Health Reimbursement Account (HRA) will be made in lieu of HSA enrollment ONLY for employees currently enrolled in Medicare Part A and/or B AND/OR those employees collecting social security income.

☐ I am currently enrolled in Medicare Part A and/or B ☐ I am currently collecting Social Security Income

*Participation in a pre-tax health savings account requires a Participation and Salary Reduction Agreement Form for enrollment for CY 2018. Annual IRS limits will apply.

☐ Point of Service (POS) Plan
  ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Employee + spouse + child(ren)

FLEXIBLE SPENDING ACCOUNT OPTIONS – for qualified medical and/or qualified dependent care expenses
Note: Participation in a pre-tax savings flexible spending account requires a Participation and Salary Reduction Agreement Form for enrollment for CY 2018. Annual IRS limits will apply.

- ☐ Health Care FSA ($2,600 annual maximum)
- ☐ Dependent Care FSA ($5,000 annual maximum)

**DENTAL INSURANCE – Aetna Freedom of Choice**

- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Employee + spouse + child(ren)
- ☐ I do not wish to purchase

Select Dental Insurance Premium Payment Method (if enrolling): ☐ Pre-tax bi-weekly payroll deduction ☐ Post-tax monthly direct billing

**VISION INSURANCE – United HealthCare**

- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Employee + spouse + child(ren)
- ☐ I do not wish to purchase

Select Vision Plan Premium Payment Method (if enrolling): ☐ Pre-tax bi-weekly payroll deduction ☐ Post-tax monthly direct billing

**LIFE INSURANCE – Aetna**

- ☐ Supplemental Life Insurance
- ☐ Spousal Life Insurance
- ☐ Dependent Child(ren) Life Insurance
- ☐ Personal Accident Insurance

Select Optional Life Insurance Premium Payment Method (if enrolling): ☐ Pre-tax bi-weekly payroll deduction ☐ Post-tax monthly direct billing

**ACKNOWLEDGMENT, AUTHORIZATION AND RELEASE**

I understand that if HRD does not receive all completed open enrollment materials required during open enrollment, current CY 2017 medical, dental, vision and/or optional life insurance elections will automatically be defaulted for CY 2018 and cannot be revoked or changed during the plan year unless I have a qualifying event as defined by IRS regulations (such as marriage, divorce, birth or adoption of child, or termination of coverage under a spouse’s plan).

I authorize the University of Hartford to enroll me in the benefits I have elected herein and to collect the associated premium based on the payment method I have selected. I agree to make the necessary premium payments for all elected coverage(s) for as long as I am enrolled in the plan(s). I understand that I can remit insurance premium(s) on a pre-tax or a post-tax basis. If I elect the post-tax monthly billing payment method and fail to remit timely premium payments for selected benefits, I understand that any and all benefit elections with an outstanding balance greater than 60 days will be cancelled retroactively to the last paid-through date. I further understand that any deductions for flexible spending or health savings accounts will be deducted from my pay on a pre-tax basis. I understand that a salary increase mid-year may impact the premium(s) associated with the coverage election per University policy and that these premiums will be adjusted accordingly.

My signature below indicates that I have read and understand this election form and the descriptive material available. The election(s) I have selected herein are binding for one year and cannot be revoked or modified except under limited circumstances (qualifying events) as defined by IRS regulations. I declare that the dependents enrolled in the benefits noted herein are my eligible dependents. I declare that the information furnished on this form is true, correct and complete to the best of my knowledge.

Signature: __________________________ Work Phone: (860) ___________ Email: __________________________@hartford.edu Date: ________________

HRD USE ONLY: [ ] PDADEDN [ ] PDABCOV Initials: _________ Date: _______________ Audit Completed: Initials: _______________ Date: _______________