PACE UNIVERSITY

Benefits Enrollment Form

University Benefits Office
100 Summit Lake Drive
Valhalla, New York 10595
TEL: 914-923-2828
FAX: 914-989-8506

CHECK REASON THAT YOU ARE COMPLETING THIS ENROLLMENT FORM:
☐ **New Hire** ☐ **Qualifying Event or Family Status Change** ☐ **Open Enrollment**

**Documentation is required for each dependent enrolled for both New Hire and to support a Qualifying Event. Submission must be within 31 days of full-time date of hire or within 31 days of the date of the Qualifying Event. New Hire must complete entire form. For Qualifying Event, complete section(s) for type of coverage impacted.*

EFFECTIVE DATE: ____/____/____ (first of the month following full-time date of hire or date of Qualifying Event or January 1st for Open Enrollment)

EMPLOYEE INFORMATION

Name (Last, First, Middle) | Marital Status | University ID Number (U#)

HEALTH INSURANCE

MEDICAL	PLAN	DENTAL	PLAN
☐ Individual	☐ Consumer Core HDHP/HSA	☐ Individual	☐ Dental DMO
☐ Employee Plus One	☐ Network Core	☐ Employee Plus One	☐ Dental PPO
☐ Family	☐ Choice Plan	☐ Family	
☐ I have other medical coverage. **Waive Participation, Elect Vision Coverage Only**		☐ Waive Coverage	
☐ I have other medical coverage. **Waive Participation, No Vision Coverage**			

HEALTH INSURANCE DEPENDENT AND PRIMARY CARE DENTIST INFORMATION (PCD SELECTION REQUIRED FOR CIGNA DENTAL DHMO)

List those eligible dependents (spouse, registered domestic partner, dependent child) for whom you are electing medical and/or dental coverage. Indicate the office selection for CIGNA Dental DHMO only. ***Please include required documentation (marriage certificate, birth certificate, etc.) for each enrolled dependent.***

MEDICAL	DENTAL	NAME	SOCIAL SECURITY #	DOB	GENDER	RELATIONSHIP TO EMPLOYEE	PCD OFFICE SELECTION # (CIGNA Dental DHMO Only)
☐	☐				☐ M ☐ F		
☐	☐				☐ M ☐ F		
☐	☐				☐ M ☐ F		
☐	☐				☐ M ☐ F		
☐	☐				☐ M ☐ F		
☐	☐				☐ M ☐ F		

REIMBURSEMENT ACCOUNTS - HEALTH CARE (FOR THOSE NOT ENROLLED IN THE CONSUMER CORE HDHP/HSA PLAN) AND CHILD AND DEPENDENT CARE

HEALTH CARE FSA ☐ AMOUNT PER PLAN YEAR $_____ January 2022 – December 2022 MAXIMUM IS $2,850. ☐ WAIVE PARTICIPATION

CHILD AND DEPENDENT CARE FSA ☐ AMOUNT PER PLAN YEAR $_____ January 2022 – December 2022 MAXIMUM IS $5,000. $2,500 IF BOTH SPOUSES CONTRIBUTE. ☐ WAIVE PARTICIPATION

HEALTH SAVINGS ACCOUNT (HSA) – FOR THOSE ENROLLED IN CONSUMER CORE HDHP PLAN ONLY

HEALTH SAVINGS ACCOUNT ☐ AMOUNT PER PLAN YEAR $_____ (through 12/31/22) ☐ WAIVE PARTICIPATION

By enrolling in the HSA, I certify that I meet the IRS eligibility requirements for the HSA. For the January 1, 2022 – December 31, 2022 plan year, $3,650 maximum for individual, $7,300 maximum for family. If participant is/will be 55 or older during the plan year, they are eligible for a $1,000 catch-up.

LIFE INSURANCE

☐ **BASIC LIFE INSURANCE**

(1x base salary, to a maximum of $100,000, provided by Pace University at no cost to the employee.)

VOLUNTARY LIFE INSURANCE

EMPLOYEE (reduces to 67% at age 70, 50% at age 75)

☐ 1X BASE SALARY
☐ 2X BASE SALARY
☐ 3X BASE SALARY

SPOUSAL ☐ **$10,000** **Name:**

DEPENDENT CHILD(REN) ☐ **$5,000** **Name(s):**

LIFE INSURANCE BENEFICIARY DESIGNATION – MORE DETAILED FORM AVAILABLE ON THE HR WEB PAGE UNDER *FORMS* SECTION

NAME	RELATIONSHIP	TYPE: PRIMARY OR CONTINGENT (REQUIRED)	BENEFIT % (REQUIRED – EACH TYPE MUST TOTAL 100%)
		☐ PRIMARY ☐ CONTINGENT	
		☐ PRIMARY ☐ CONTINGENT	
		☐ PRIMARY ☐ CONTINGENT	
		☐ PRIMARY ☐ CONTINGENT	
		☐ PRIMARY ☐ CONTINGENT	

I certify that the above is true and correct. For New Hire: I acknowledge that I have reviewed the New Employee Orientation narrated PowerPoint presentation and have contacted the University Benefits office if any information is unclear. By not enrolling in certain benefits at this time (within 31 days of full-time date of hire or within 31 days of a qualifying change in family status), I understand that I will be unable to enroll or make changes again until the next annual Open Enrollment period. I hereby authorize Pace University to reduce my pay for the benefit plans that I have selected above.

Employee Signature | Date