UNIVERSITY PHYSICIANS
BROOKLYN, INC.

Benefit Enrollment/Change Form

Shaded items to be completed by ***UPB Human Resources Department***

Hire Date: Effective Date: ☐ Bi-Weekly ☐ Monthly

SECTION 1: Information About You *Please print clearly all the following information*

Name: ____________________ (First) ____________________ (Last) Social Security #: ____________ Department: ____________

Address: ________ (Street) ________ (Apt #) ________ (City) ________ (State) ________ (Zip) Date of Birth: ____________

Home Phone Number: ____________________ Business Phone Number: ____________________

Action: (Check One) ☐ New Hire Enrollment ☐ Status Change ☐ 401(k) Election Only
☐ Re-Hire Enrollment ☐ Family Status Change ☐ Open Enrollment

SECTION 2: Medical Plan Type *Choose One* ☐ Basic Plan ☐ High Plan

SECTION 3: Medical Coverage *Please check the coverage level for medical you want*
☐ Employee Only ☐ Employee + Spouse/ Partner * ☐ Employee + child(ren) ☐ Employee Family
☐ I decline coverage under the University Physicians of Brooklyn, Inc. Plan Reason: ____________________

SECTION 4: Dental Coverage *Please check the coverage level for dental you want*
☐ Employee Only ☐ Employee + Spouse/Partner * ☐ Employee + child(ren) ☐ Employee Family
☐ I decline coverage under the University Physicians of Brooklyn, Inc. Plan Reason: ____________________

SECTION 5: Vision Coverage *Please check the coverage level for vision that you want*
☐ Employee Only ☐ Employee + Spouse/Partner * ☐ Employee + child(ren) ☐ Employee Family
☐ I decline coverage under the University Physicians of Brooklyn, Inc. Plan Reason: ____________________
** if you are electing coverage for your Partner, you must complete the Declaration of Partnership Form and provide three types of proof.*

SECTION 6: Personal Information *Please provide the information requested for you and each dependent for whom you are electing coverage*

First Name	Last Name	Social Security #	Gender	Birth date	Relationship
					Self
					Spouse/Partner
					Child
					Child
					Child

SECTION 7: Flexible Spending Account (FSA) Elections (*Note: IRS may limit amount you can contribute)*
Please indicate whether you want to participate in Health Care and/or Dependent Care Account(s) and provide the annual amount you want to contribute.

For the Health Care FSA, I elect:
☐ To contribute this amount from my pre-tax pay: $ ____________ ($5,000 maximum per year)
☐ Not to participate

For the Dependent Care FSA, I elect:
☐ To contribute this amount from my pre-tax pay: $ ____________ ($5,000 maximum per year)
☐ Not to participate

SECTION 8 : Basic Life Insurance Beneficiary Designation Attach separate form, if necessary.

Primary Beneficiaries –Name	Relationship	Social Security #	Date of Birth	Percent of Benefit	**Contingent Beneficiaries –Name**	Relationship	Social Security #	Percent of Benefit	Date of Birth

SECTION 9: Supplemental Life Insurance Coverage *Please check the coverage level for Supplemental Life Insurance that you want*
☐ Employee Only ☐ Employee + Spouse/Partner ☐ Employee + child(ren) ☐ Employee Family ☐ I decline coverage

SECTION 10: Supplemental Life Insurance Beneficiary Designation ☐ Same as the Basic Life Insurance Beneficiary Designation or attach separate form

SECTION 11: 401(k) Contribution Election Maximum contribution amount is $17,500.00 Maximum contribution amount for those over 50 years of age is $23,000.00
For 401(k) participation, I elect:
☐ To have a salary reduction contribution from my pre-tax pay: $__________ ☐ To have a percentage of my salary deducted from my pre-tax pay: _______
☐ Not to participate

SECTION 12: 401(k) Provider Election Complete and attach the original provider enrollment form, found in your enrollment kit, to this form to set up your 401(k) account. Deductions cannot begin until the original provider enrollment form has been received.
For 401(k) participation, I elect: ☐ TIAA CREF ☐ CATCH UP

SECTION 13: 401(k) Beneficiary Designation Please provide the requested information for the beneficiaries you are electing for your 401(k). If you elect more than one Primary or Contingent Beneficiary, your total percent of benefit must equal 100%. If you are married and wish to designate someone other than your spouse as your primary beneficiary, your spouse must complete, sign and have notarized the Spousal Consent Form. If you wish to change the designated beneficiary(ies) at a later date, to a different non-spouse beneficiary, a new Spousal Consent Form will be required. A change in marital status may render your beneficiary designation null and void and if you do not make a new beneficiary designation, any death benefits will be payable under the Plan's terms. All designations specified on this form will remain in full force until a change in beneficiary designation form is signed by you and, properly submitted, takes effect.

Primary Beneficiaries –Name	Relationship	Social Security #	Percent of Benefit	**Contingent Beneficiaries –Name**	Relationship	Social Security #	Percent of Benefit

SECTION 14: Authorization *Please read the following information carefully and then sign and date this form. Your completed form should be returned to Human Resources*. I have read the materials regarding my University Physicians of Brooklyn (UPB) benefit options. I elect the options indicated on this form. I authorize UPB to reduce my base pay by the amount needed to maintain the benefit elections on this form. I understand that any missed premiums will be retroactively deducted in lump sum from my paycheck. **I understand that I cannot cancel or change my coverage elections at anytime, and that coverage can only be canceled or changed during the company designated Open Enrollment period or within 31-days of a Qualifying Life Event.** However, changes to my 401(k) elections or Beneficiaries can be made at any time.

Your Signature: ______________________________ **Date:** ____________________

Before submitting your form review the following items:
☐ Have you selected 401(k) and life insurance beneficiaries
☐ Have you read through the entire Benefit Enrollment Material
☐ Attached a Marriage License/ Birth Certificate/Partner Application and proof
☐ Have you signed the Benefit enrollment form
☐ Attached the Original 401(k) Provider Enrollment Form

Please be advised that Medical Insurance Cards will be mailed to you within three weeks, contingent on a completed and processed enrollment form. You can check the status of your card(s) by calling ***Aetna*** *at* ***1-800-962-6842*** *or you may print a temporary card by logging on and registering at www.aetna.com. All cards will be mailed to your home within 3 weeks, contingent on the completion and processing of your enrollment form.*

Please keep a copy of this form for your records before submitting to Human Resources