DOWNSTATE HEALTH PHYSICIANS

Benefit Enrollment/Change Form

Shaded items to be completed by DHP Human Resources

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

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

Name: _____ Social Security #: _____ Department: _____
First Last

Address: _____ Date of Birth: _____
Street Apt # City State Zip

Home Phone Number: _____ Email Address: _____

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

SECTION 2: Medical Coverage Check both the plan **and** coverage level you want

☐ Basic Plan ☐ High Plan

☐ Employee Only ☐ Employee + Spouse/ Partner ☐ Employee + child(ren) ☐ Employee Family

☐ I decline coverage under the University Physicians of Brooklyn, Inc. Plan Reason: _____

SECTION 3: Dental Coverage Check the coverage level you want **and also** complete the separate Delta Dental Enrollment form

☐ Employee Only ☐ Employee + Spouse/Partner ☐ Employee + child(ren) ☐ Employee Family

☐ I decline coverage under the University Physicians of Brooklyn, Inc. Plan Reason: _____

SECTION 4: Vision Coverage Check the coverage level you want **and also** complete the separate VSP Enrollment form

☐ Employee Only ☐ Employee + Spouse/Partner ☐ Employee + child(ren) ☐ Employee Family

☐ I decline coverage under the University Physicians of Brooklyn, Inc. Plan Reason: _____

SECTION 5: Enrollee 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 6: Voluntary Life Insurance Coverage Check the coverage level you want **and also** complete the separate Mutual of Omaha Evidence of Insurability form. This is for coverage in addition to the Basic Life and AD&D Insurance coverage guaranteed to full time employees.

☐ Employee Only ☐ Employee + Spouse/Partner ☐ Employee + child(ren) ☐ Employee Family ☐ I decline coverage

SECTION 7: Flexible Spending Account (FSA) Check whether you want to participate in Health Care and/or Dependent Care Account(s) and provide the annual amount you want to contribute **and also** complete the separate FSA Election form

For the Health Care FSA, I elect:

☐ To contribute this amount from my pre-tax pay: $ _____

☐ Not to participate $3,200 maximum per year

For the Dependent Care FSA, I elect:

☐ To contribute this amount from my pre-tax pay: $ _____

☐ Not to participate $5,000 maximum per year

SECTION 8: TIAA CREF 401(k) Provide an election amount below **and also** complete the separate TIAA CREF enrollment booklet. Maximum annual contribution is $23,000.00, plus an additional contribution allowance for those over 50 years of age of $7,500.00

For 401(k) participation, I elect:

☐ To have a salary reduction contribution from my pre-tax pay: $_____ ☐ per pay period ☐ per year total

☐ To have a percentage of my salary deducted from my pre-tax pay: _____

☐ Not to participate

SECTION 9: Transit Benefits Please provide an election amount for commuter benefits. You will receive instructions for online registration.

☐ To contribute this amount from my pre-tax pay: $ _____ per month ☐ Not to participate

$315 maximum per month

SECTION 10: 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 Downstate Health Physicians (DHP) benefit options. I elect the options indicated on this form. I authorize DHP 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 medical, dental, vision, life insurance, and FSA 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) and transit benefit elections can be made at any time.

Your Signature: _____ **Date:** _____

Before submitting your form review the following items:

☐ 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 individual Provider Enrollment Forms

RESET ALL

Last edit 01/11/2024

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

Back to Top