



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:

- Open Enrollment
Qualifying Event or Family Status Change
New Hire

*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.

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 Employee Plus One Family
Consumer Core HDHP/HSA Network Core Choice PPO
Individual Employee Plus One Family Waive Coverage
CIGNA Dental DHMO CIGNA Dental PPO

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.

Table with columns: MEDICAL, DENTAL, NAME, SOCIAL SECURITY #, DOB, GENDER, RELATIONSHIP TO EMPLOYEE, PCD OFFICE SELECTION # (CIGNA Dental DHMO Only)

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

HEALTH CARE FSA CHILD AND DEPENDENT CARE FSA
AMOUNT PER PLAN YEAR
January 2021 - December 2021 MAXIMUM IS \$2,750.
January 2021 - December 2021 MAXIMUM IS \$5,000. \$2,500 IF BOTH SPOUSES CONTRIBUTE.

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

HEALTH SAVINGS ACCOUNT AMOUNT PER PLAN YEAR (through 12/31/21) WAIVE PARTICIPATION

By enrolling in the HSA, I certify that I meet the IRS eligibility requirements for the HSA. For the January 1, 2021 - December 31, 2021 plan year, \$3,600 maximum for individual, \$7,200 maximum for family.

LIFE INSURANCE

BASIC LIFE INSURANCE VOLUNTARY LIFE INSURANCE SPOUSAL DEPENDENT CHILD(REN)
(1x base salary, to a maximum of \$100,000, provided by Pace University at no cost to the employee.)
EMPLOYEE (reduces to 67% at age 70, 50% at age 75)
1X BASE SALARY 2X BASE SALARY 3X BASE SALARY
Name: Name(s):

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

Table with columns: NAME, RELATIONSHIP, TYPE: PRIMARY OR CONTINGENT (REQUIRED), BENEFIT % (REQUIRED - EACH TYPE MUST TOTAL 100%)

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.

Employee Signature Date