

SECTION 6: LIFE INSURANCE

You MUST complete the beneficiary information. If you list more than one primary or secondary beneficiary please indicate the amount you wish to designate to each.

Primary Beneficiary

Name	Social Security Number	Date of Birth	Relationship	Amount or % (if more than one beneficiary)	Phone or Address

Secondary Beneficiary

Name	Social Security Number	Date of Birth	Relationship	Amount or % (if more than one beneficiary)	Phone or Address

You MAY choose any of the following life insurance options.

Supplemental Employee Life Insurance in the amount of:
 (Coverage available in \$10,000 increments up to *\$500,000)
 *100,000 for members of AFSCME Bargaining Unit

Dependent Life Insurance (Choose only *one) *Option C is not available to AFSCME members

Option A (\$10,000 spouse, \$5,000 each child)
 Option B (\$5,000 spouse, \$2,000 each child)
 Option C (\$20,000 spouse, \$10,000 each child)

If you are a **PART-TIME CLASSIFIED EMPLOYEE** and want to purchase Basic Life Insurance, please check here (Part-time employees must purchase Basic Life Insurance to enroll in Supplemental Coverage).

SECTION 7: FLEXIBLE SPENDING ACCOUNT

<input type="checkbox"/> Health Account in the amount of (\$5,000 maximum): <input type="text" value="\$"/> <input type="checkbox"/> Day Care Account in the amount of (\$5,000 maximum): <input type="text" value="\$"/>	Enter the TOTAL amount to be deducted over the next plan year (July – June). Faculty deductions based on nine pays, Oct-June.
--	---

SECTION 8: AUTHORIZATION

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (IES) issued to or by Ohio University. I understand that if I am not actively at work as defined in the policy on the date my coverage would otherwise become effective my insurance will not begin until the day I meet the policy definition of actively at work. For those insurance coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire required.

I certify all information is true and correct to the best of my knowledge. I understand that my elections may not be changed or voluntarily canceled at any time during the plan year unless a qualifying family status change or other qualifying event, as defined by federal regulations, occurs. Otherwise, I may only cancel or make changes during the annual open enrollment.

Please Note: Rates for part-time classified employees are based on hours worked each pay period.

EMPLOYEE SIGNATURE _____ DATE _____

RETURN TO:

Ohio University Human Resources
 169 West Union Street
 Human Resources & Training Center
 Athens, OH 45701-2979

BENEFITS OFFICE USE ONLY			
Oracle	___/___/___	Admin	___ AFSCME ___
Anthem	___/___/___	Faculty	___ FOP ___
VSP	___/___/___	NBU Class	___
			Initials _____