DePauw University

Group Health Insurance Plan Enrollment Form (2006-07)

1) ____ ________________________________
Name of Employee **Social Security Number**

2) **Do you wish to elect medical coverage?** _____ **Yes** _____ **No**

If "yes", select a medical insurance carrier. _____ **CIGNA POS** _____ **CIGNA OA Plus**

3) **Do you wish to elect dental coverage?** _____ **Yes** _____ **No**

4) **How many eligible individuals will be covered by your Group Health Insurance Plan?**

_____ **Employee only**
_____ **Employee + 1 dependent**
_____ **Employee + 2 or more dependents**
_____ **Employee + 3 or more dependents**

5) **Please provide the following information for yourself and all eligible dependents to be covered under your Group Health Insurance Plan:**

Full Name	Relationship	Date of Birth	Name of College (For dependents age 19 < 25 only)	Name of Primary Care Physician (If known)
	Employee			

6) **GENERAL TERMS AND CONDITIONS -** You acknowledge and understand the following:

a) The Salary Reduction Agreement for the 2006-07 Plan Year is effective from July 1, 2006 through June 30, 2007.
b) You may not change your plan election(s) unless you have a change in family status and you notify the Office of Human Resources within 31 days of the change in family status.
c) If the cost of any group health insurance benefit which you have elected should change, DePauw University is authorized to adjust the amount and also make the appropriate reductions in your pay to maintain the benefit elections.
d) DePauw University may modify this agreement if it becomes necessary to satisfy certain provisions of the Internal Revenue Code.

7) **INSURANCE PREMIUM -** Your Annual Insurance Premium for the 2006-07 Plan Year is $__________________.

8) **SIGNATURE OF EMPLOYEE -** Your signature confirms that you understand the terms and conditions above.

Employee's Signature ____ Date:________________

Employee's Campus Phone Number ____

9) **EFFECTIVE DATE -** Your benefit effective date will be ________________________________.