

BENEFITS ENROLLMENT FORM

Name _____ Last First M.I.		_____-_____-_____ Social Security Number	
Campus Address _____ Zip Code _____		University ID Number _____	
Campus Phone _____		Email Address _____	
1. ADMINISTRATIVE UNIT [] UNL [] IANR [] UNMC [] UNO [] UNK [] UNCA	2. PAY CYCLE [] BIWEEKLY [] MONTHLY	3. DATE OF HIRE/ELIGIBILITY _____/_____/_____ month day year	4. DATE OF BIRTH _____/_____/_____ month day year
5. EFFECTIVE DATE _____/_____/_____ month day year		8. NUFLEX CHOICES	
6. SPOUSE IS AN EMPLOYEE OF THE UNIVERSITY OF NEBRASKA Spouse's Name: _____ Spouse's Social Security Number: _____		Medical _____	Coverage Category _____
7. TOBACCO/NICOTINE DESIGNATION (for life insurance enrollment) Have you used any form of tobacco or nicotine, including nicotine substitutes (e.g. patches or gum) within the last 12 months? ___ Yes ___ No If No, complete the following: Date quit using tobacco/nicotine _____ OR [] Never Used month day year		Dental _____	_____
		Vision _____	_____
		Long Term Disability _____	_____
		Life Insurance Employer-Provided (1x Annual Budgeted Salary*) _____	_____
		Voluntary Life Insurance _____	_____
		Accidental Death & Dismemberment _____	_____
		Dependent Life Insurance _____	_____
		Spouse _____	_____
		Child(ren) _____	_____
		Flexible Spending Account _____	_____
		Health Care \$_____ Total amount through December 31	_____
		Dependent Day Care \$_____ Total amount through December 31	_____
		*Up to a \$120,000 maximum	
9. PRIMARY BENEFICIARY NAME: _____ RELATIONSHIP: _____			
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____			
SECONDARY BENEFICIARY NAME: _____ RELATIONSHIP: _____			
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____			
10. EMPLOYEE SIGNATURE I understand and approve the enrollment as indicated above. In accordance with Nebraska Revised Statute §48-1230 (Reissue 2010), I hereby authorize the Board of Regents of the University of Nebraska (Employer) to deduct from my earnings the amount of my premiums or other contributions (if any) for the benefit options noted in Section 8 above. I understand that I will not pay income tax or FICA tax on my medical, dental, vision, long term disability, and employee only AD&D insurance premiums, or Flexible Spending Account contributions. These benefits are paid through the Flexible Benefits Plan on a pre-tax basis. Coverage for long term care insurance, voluntary life insurance, dependent life insurance, and family AD&D insurance is not provided through the Flexible Benefits Plan on a pre-tax basis. Life insurance that exceeds \$50,000 may be subject to imputed income. However, my gross salary before these deductions will be used to figure salary increases or pay-related fringe benefits. Under the Internal Revenue Code regulations rules, I may not change my benefit elections (Section 8 above) during the calendar year unless I experience a qualified change in status. For information on what constitutes a qualified change in status, see the detailed benefits information at www.nebraska.edu/benefits . (Health Care Flexible Spending Account elections may not be reduced during the calendar year.) Each year, during the annual enrollment period, I will have the option to change certain coverages whether or not I have had a qualified change in status event during the calendar year (some benefits may have certain enrollment restrictions). In the future, any application to add or increase coverage for me or any of my dependents may require proof of insurability for any person proposed for coverage. Any application must be submitted in accordance with university and/or insurance company guidelines. If you decline medical insurance enrollment for yourself or your dependents, including your spouse, because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new spouse or dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself, your spouse and your dependents, provided that you request enrollment within 31 days after the marriage, birth or adoption. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Any material misrepresentation made by me in the above "Tobacco/Nicotine Designation," including my tobacco/nicotine use history, may void the insurance, pursuant to the Incontestable Clause of the policy.			
EMPLOYEE SIGNATURE _____		DATE _____	

BENEFITS ENROLLMENT FORM INSTRUCTIONS

Use this Benefits Enrollment Form to enroll for your University of Nebraska benefits. NUFlex offers you a variety of benefit and insurance options that are explained in detail in your enrollment materials. Contact your Campus Benefits Office for additional information or questions regarding benefit coverage and costs.

You are eligible for University of Nebraska provided benefits under the NUFlex program if you are employed in a "Regular position" with an FTE of .5 or greater or employed in a "Temporary position" for more than 6 months with an FTE of .5 or greater.

Review your benefit materials carefully. Complete the "Option Number" and "Coverage Category" choices and any Flexible Spending Account contributions in Section 8.

If you elect not to have coverage in one or more benefit plans, or if you wish to increase or add insurance coverage for you or any dependent(s) in the future, you and/or any dependent(s) proposed for coverage may need to satisfy proof of insurability as required by the insurance company.

Under the current tax law, your benefit selections are in force for the balance of the calendar year. You may make changes only if you experience a qualified change in status. For information on what constitutes a qualified change in status, see the detailed benefits information at www.nebraska.edu/benefits. Any application for changes and/or additions of coverage must be received in your Campus Benefits Office within 31 days of the qualified change in status event. Once your Benefits Enrollment Form has been submitted to the Campus Benefits Office, no changes will be allowed until the next annual NUFlex enrollment period or a Permitted Election Change Event Occurs. New employees may apply for any medical option. No medical option changes, however, will be permitted except during the annual NUFlex enrollment period.

Your payroll deductions for certain University of Nebraska provided benefits are **salary reductions** under the Flexible Benefits Plan. This means that you will not pay federal or state income tax or Social Security tax on the cost of these benefits. Because your premiums for these benefits are tax-exempt, you save on taxes which reduces the net cost to you. However, the following types of coverage are not offered under the Flexible Benefits Plan, do not qualify for pre-tax treatment, and are paid for with after-tax dollars: long term care insurance, voluntary life insurance, dependent life insurance, and family AD&D insurance.

Please print clearly and complete the forms in ink, not pencil. Begin by filling in your name (last name first), Campus Address, Campus Phone, Social Security Number, University ID Number, and Email Address.

1. **Administrative Unit:** Check the administrative unit to which you report. This is not always the same as the campus on which you are located. Check UNL (University of Nebraska-Lincoln), **IANR** (Institute of Agriculture and Natural Resources), **UNMC** (University of Nebraska Medical Center), **UNO** (University of Nebraska at Omaha), **UNK** (University of Nebraska at Kearney), or **UNCA** (Central Administration and Computing Services).
2. **Pay Cycle:** Check **One-biweekly** if you are paid every two weeks, **monthly** if you are paid monthly.
3. **Date of Hire/Eligibility:** If you are a new employee, fill in the date that your employment began at the University of Nebraska. If you are newly eligible for benefits, fill in the date in which you met the benefits eligibility requirements.
4. **Date of Birth:** Complete with your birth date.
5. **Effective Date:** Indicate the date your benefits are to begin. This will be the first of the month following your date of hire/eligibility. If the date of hire/eligibility is the first working day of the month, then coverage would begin on that date.
6. **Spouse Employment:** Check **only** if your spouse is currently employed by the University of Nebraska. Include your spouse's **name** and **Social Security Number** in the spaces provided. If your spouse is employed by the University of Nebraska, the cost of your benefits may be reduced by contributions from your spouse's department. Contact your Campus Benefits Office for more information.
7. **Tobacco/Nicotine Designation:** The Tobacco/Nicotine Designation request only applies to the group voluntary life insurance benefit. Indicate Yes (have used tobacco or nicotine within the last 12 months) or No (have not used any form of tobacco or nicotine within the last 12 months). If you indicated No, include the date you quit using tobacco/nicotine; or if you have never used tobacco/nicotine, indicate "never used."
8. **NUFlex Choices:** Complete the appropriate Option Numbers and Coverage Category. The corresponding price tags for these selections are shown on the NUFlex Price Tag Summary. For Flexible Spending Account salary reductions, enter the total annual amount you want deducted through December 31. Health Care Flexible Spending Account elections may not be reduced during the calendar year.
9. **Primary and Secondary Beneficiary Names:** The Primary Beneficiary may be one or more persons (or a trust) you designate to receive life insurance death benefits should you die. The beneficiary must be "named" which requires you to provide the names of your children rather than requesting "My Children." Death benefits will be distributed equally to any surviving primary beneficiaries. If there are no surviving primary beneficiaries, death benefits will be provided to the secondary beneficiaries.

SIGNATURE REQUIREMENTS

10. **Employee Signature:** The application must be signed by you.