

## EMPLOYEE PLUS ONE BENEFITS ENROLLMENT FORM

Name _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> <span>Last</span> <span>First</span> <span>M.I.</span> </div>	_____ Social Security Number
Campus Address _____ Zip Code _____ Campus Phone _____	University ID Number _____ Email Address _____

<b>1. ADMINISTRATIVE UNIT</b> <input type="checkbox"/> UNL <input type="checkbox"/> IANR <input type="checkbox"/> UNMC <input type="checkbox"/> UNO <input type="checkbox"/> UNK <input type="checkbox"/> UNCA	<b>2. PAY CYCLE</b> <input type="checkbox"/> BIWEEKLY <input type="checkbox"/> MONTHLY	<b>3. DATE OF HIRE/ELIGIBILITY</b> ____ / ____ / ____ <div style="display: flex; justify-content: space-around; width: 80%; margin: 0 auto;"> <span>month</span> <span>day</span> <span>year</span> </div>	<b>4. DATE OF BIRTH</b> ____ / ____ / ____ <div style="display: flex; justify-content: space-around; width: 80%; margin: 0 auto;"> <span>month</span> <span>day</span> <span>year</span> </div>
--	--	--	---

**5. EFFECTIVE DATE**  
 \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 month      day      year

**6. ADULT DESIGNEE IS AN EMPLOYEE OF THE UNIVERSITY OF NEBRASKA**

Adult Designee's Name: \_\_\_\_\_

Adult Designee's Social Security Number:  
 \_\_\_\_\_

**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

8. NUFLEX CHOICES	Option Number	Coverage Category
Medical	_____	_____
Dental	_____	_____
Vision	_____	_____
Long Term Disability	_____	
Life Insurance Employer-Provided (1x Annual Budgeted Salary*)		
Voluntary Life Insurance	_____	
Accidental Death & Dismemberment	_____	_____
Dependent Life Insurance		
Adult Designee	_____	
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. 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. Coverage related to Employee Plus One dependents may be a taxable benefit and may be subject to imputed income for tax purposes. In addition, 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, 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](http://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 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 Adult Designee, 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. If you have a new dependent as a result of birth or adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 31 days after the 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 \_\_\_\_\_

## EMPLOYEE PLUS ONE 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](http://www.nebraska.edu/benefits). Any application for changes and/or additions of coverage as well as related documentation 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. 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. Generally, coverage related to Employee Plus One dependents is a taxable benefit and may also be subject to imputed income.

Please print clearly and complete the forms in ink, not pencil. Begin by filling in your name (last name first), Campus Address, Campus Phone Number, 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. **Adult Designee Employment:** Check **only** if your Adult Designee is currently employed by the University of Nebraska. Include your Adult Designee's **name** and **Social Security Number** in the spaces provided. If your Adult Designee is employed by the University of Nebraska, the cost of your benefits may be reduced by contributions from your Adult Designee'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 Employee Plus One 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.

## **SIGNATURE REQUIREMENTS**

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