



Benefits Enrollment Form

If you are a full-time non-exempt staff member (paid weekly or every two weeks), your benefits begin on the first of the month following 60 days of employment and this form MUST be received within 60 days from hire date.

Form with checkboxes: New Hire, Part-time to Full-time, Rehire

If you are a full-time exempt faculty/staff member (paid monthly), your benefits begin on your hire date and this form MUST be received within 30 days from hire date.

Faculty/Staff Information (Please print clearly)

Form with fields for Social Security Number, Last Name, First Name, M.I., Date of Birth, Home Mailing Address, City, State, Zip, Daytime Phone Number, Date of Hire, Department, and checkboxes for gender and spouse status.

Health

Health Option and Health Coverage Level selection checkboxes.

If you do not indicate an option, you will be enrolled in the default: Aetna Standard with coverage only for yourself

Dental (Optional)

Dental Plan and Dental Coverage Level selection checkboxes.

(If you do not indicate a facility, one will be assigned to you.)

Vision (Optional)

Vision Coverage Level selection checkboxes.

Covered Family Members (By including your spouse/certified partner and/or children, you assert they meet eligibility requirements. Attach second sheet if necessary.)

Table with columns: Relationship, Last Name, First Name, Social Security Number, Date of Birth, Gender, and Enroll In (Health, Dental, Vision).

Life Insurance

Form for Life Insurance with fields for Basic Coverage, Supplemental Coverage, Beneficiary Name, Relationship, and Percentage.

Accidental Death & Dismemberment (Optional) Maximum coverage is 10x your salary or \$500,000 (whichever is less).

Form for Accidental Death & Dismemberment with fields for Coverage Amount, Coverage Level, Beneficiary Name, Relationship, and Percentage.

Processing Office Use Only box with fields for Pay Group, Eff Date Health, Eff Date Life, Correction Mode Needed, ID #, and Date Received in Processing.

When declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be eligible to enroll yourself or your eligible dependents in the Vanderbilt Plan provided you request enrollment within 30 days of other coverage ending.

I have received information about Vanderbilt University's benefits. I choose to enroll as indicated above and waive my right to participate in the plans not selected. I understand enrollment at a later date in plans not selected may require proof of insurability.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Return form to: HR Processing, VU Station B # 357718, 2301 Vanderbilt Place, Nashville, TN 37235-7718

\* Requires certification of same-gender partnership. Contact the Office of Benefits Administration to make an appointment. \*\* If a beneficiary is not named, the default beneficiary will be your estate.