MOUNT VERNON NAZARENE UNIVERSITY
Life Changing

ENROLLMENT APPLICATION ❑ New Enrollment ❑ Change Enrollment ❑ Open Enrollment

EMPLOYEE INFORMATION

Employee Name							
Social Security Number							
Job Location	❑ 001 Mt. Vernon ❑ 002 Newark ❑ 003 Mansfield ❑ 004 New Albany						
Address							
City			State		Zip Code		
Date of Birth		Gender (M / F)		Marital Status[1]			
Date of Hire		Job Title	❑ Admin ❑ Faculty ❑ Staff ❑ Retired				

[1] Single (S), Married (M), Divorced (D), Widowed (W)

COVERAGE SELECTION

Medical				
Plan 1 (PPO) Payroll Deduction	❑ Employee Only $110 / Month	❑ Employee + One $372 / Month	❑ Family $444 / Month	❑ Family / 2 EE's $272 / Month
Plan 2 (HDHP) Payroll Deduction	❑ Employee Only $45 / Month	❑ Employee + One $150 / Month	❑ Family $175 / Month	❑ Family / 2 EE's $130 / Month
Waiver	❑ I decline to participate in the medical insurance plan. I have read the provisions on page three (3) concerning special enrollment to which I or my dependents may be entitled at a later date.			
Vision Payroll Deduction	❑ Employee Only $8.50 / Month	❑ Employee + One $14.44 / Month	❑ Family $18.42 / Month	
Waiver	❑ I decline to participate in the vision insurance plan. I have read the provisions on page three (3) concerning special enrollment to which I or my dependents may be entitled at a later date.			

SAVINGS ACCOUNT SELECTIONS

Flexible Spending Account – Unreimbursed Medical	Annual Election – Limited to $2,500		❑ Limited Scope ❑ Full	❑ Waive
Flexible Spending Account – Dependent Care	Annual Election – Limited to $5,000 per household			❑ Waive
Automatic Reimbursement Enrollment	❑ Yes ❑ No	The automatic reimbursement feature gives you the ability to have claims automatically reimbursed by the flexible spending account as they are paid.		
Direct Deposit Authorization	❑ Savings Account (attach a deposit slip) ❑ Checking Account (attach a voided check)			
Health Savings Account	Annual Election – Limited to $3,300 Single and $6,550 Family From All Sources Combined			❑ Waive

Note: Deposits cannot be made to a Full Unreimbursed Medical Flexible Spending Account and a Health Savings Account in the same tax year.

DEPENDENT INFORMATION

	Dependent Name	Date of Birth	Relationship	Social Security Number	Gender	Covered by Other Medical Insurance**
1.						❑ Yes ❑ No
2.						❑ Yes ❑ No
3.						❑ Yes ❑ No
4.						❑ Yes ❑ No
5.						❑ Yes ❑ No

**If covered by other medical insurance, please provide the name of the carrier, company, type of coverage and effective date:

_____

CHANGE ENROLLMENT – Complete this section only if this is a change enrollment .

Please check reason for change:

❑ Employee Name Change ❑ Employee Address Change ❑ Job Location Change
❑ Job Title Change ❑ Return to Work ❑ Other coverage change
❑ Date of Marriage _____ ❑ Date of Divorce _____ ❑ Add Dependents
❑ Eligible for Medicaid/CHIP Subsidy ❑ Loss of Eligibility for Medicaid / CHIP Subsidy
❑ Voluntary Terminate Coverage (indicate which coverages) _____
❑ State / Federal Continuation ❑ Add Coverage
❑ Remove Dependents (list names) _____ Reason: _____
❑ Employment Termination: Reason: _____ Last Day Worked: _____
❑ Other _____

READ, SIGN AND DATE BELOW

I hereby certify that all of the information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change until the plan's next open/annual enrollment period or unless otherwise permitted by the plan. Please refer to your summary plan description for specific details on your benefit plan.

❑ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

Printed Name MVNU ID# _____

Signature Date _____

Important Enrollment Information

Group health plans may not establish eligibility rules based on any of the following health status-related factors; medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

Your Plan contains a provision which limits or denies benefits for pre-existing conditions. This provision can apply for a maximum of 12 months for new employees and their dependents age 19 and above. Consult you Plan Document or Summary Plan Description for specific information on how a preexisting condition is determined.

If you have been covered under a group health plan through your previous employer, you and/or your dependents may be entitled to offset the period for which a pre-existing condition limitation applies. You should have received, or are entitled to receive, a Certificate of Coverage from your prior employer. A copy of that Certificate should be attached to this Enrollment Form. If you are entitled to a partial credit against the pre-existing period for this prior credible coverage, you will be advised of the credit in writing. If you have 12 months of prior credible coverage, you will not be subject to pre-existing limitations, and will receive no written notification to this effect.

Group plans are required to provide special enrollment periods for individuals who do not enroll in the plan at the first opportunity because of other coverage, and subsequently lose this other source of coverage. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the plan, provided you request such enrollment in writing within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.