2022 POSTDOC ASSOCIATES & SCHOLARS BENEFITS ENROLLMENT FORM

EMPLOYEE INFORMATION

Name:_____**GWID:**_____

Date of Birth: _____ **Date of Hire:** _____ **Sex:** Male ☐ Female ☐

Street: _____ **City, State:** _____ **Zip code:** _____

Phone Number: _____ **Email**: _____

Employment Status: Full-Time ☐ Part-Time ☐ **Pay Frequency:** Biweekly ☐ Monthly ☐

SELECT QUALIFIED LIFE EVENT (QLE)

Changes are only permitted within 30 calendar days of a Qualified Life Event (QLE). Any changes made as a result of a QLE must be consistent with that event and documentation must be provided along with this enrollment form. Benefit changes will be effective the 1st of the month following receipt of documentation, as long as it is received within 30 calendar days from the QLE date.

☐ **New Hire/Rehire**
☐ **2022 Open Enrollment**
☐ **Birth/Adoption/Legal Guardianship**
☐ **Participant Loss or Gain of Coverage**
☐ **Spouse/Domestic Partner – Loss/Gain of Coverage**
☐ **Job Status Change (i.e., PT to FT, FT to PT, etc.)**
☐ **Marriage/Newly Eligible Domestic Partner**
☐ **Divorce/Legal Separation/Annulment**
☐ **Taking or Returning from a Leave of Absence**
☐ **Other:**

_____

DEPENDENT(S) TO BE COVERED:

You may cover your spouse or domestic partner and/or dependent children under the medical plan. Please complete the information below for each individual you wish to cover or remove from coverage. This form will not be processed until documentation verifying dependent eligibility is received (e.g., birth certificate, marriage certificate, etc.). Please note: Your domestic partner must also be enrolled in order to cover their child.

Dependent Name (#1): _____ **DOB** _____ **SSN**: _____

Relationship: Spouse ☐ Domestic Partner ☐ Child ☐
Tax Dependent: Yes ☐ No ☐ **Disabled:** Yes ☐ No ☐
Enroll in: Medical ☐ Dental ☐ Vision ☐

Dependent Name (#2): _____ **DOB** _____ **SSN**: _____

Relationship: Spouse ☐ Domestic Partner ☐ Child ☐
Tax Dependent: Yes ☐ No ☐ **Disabled:** Yes ☐ No ☐
Enroll in: Medical ☐ Dental ☐ Vision ☐

Dependent Name (#3): _____ **DOB** _____ **SSN**: _____

Relationship: Spouse ☐ Domestic Partner ☐ Child ☐
Tax Dependent: Yes ☐ No ☐ **Disabled:** Yes ☐ No ☐
Enroll in: Medical ☐ Dental ☐ Vision ☐

Dependent Name (#4): _____ **DOB** _____ **SSN**: _____

Relationship: Spouse ☐ Domestic Partner ☐ Child ☐
Tax Dependent: Yes ☐ No ☐ **Disabled:** Yes ☐ No ☐
Enroll in: Medical ☐ Dental ☐ Vision ☐

DEPENDENT VERIFICATION

☐ By checking this box, you are confirming that you have read and understood all the plan terms, and you certify that all of the individuals you have requested to enroll (including yourself) are eligible to be covered. Your enrollment of any individual who is not eligible under the terms of the plan may be treated as fraud, resulting in termination of the individual's coverage retroactive to the original enrollment date and the recovery of any claims paid, to the extent allowed by law.

Special Note - Benefits and Income Taxes:

Associates: *IRS regulations mandate that the value of GW's contributions to healthcare benefits for domestic partners of Associates and their eligible children be considered taxable income to the Associate.*

Scholars: *IRS regulations mandate that the value of the GW benefits for Scholars and their eligible dependents be considered taxable income to the Scholar.*

Please select one option below. If you select coverage other than Employee Only, you must provide dependent information in the Dependent Section of this form

---

Please review the benefit options presented below and select the benefits that best suit your individual/family needs. Options not clearly designated or left blank will be considered to be waived.

MEDICAL

UnitedHealthcare GW Postdoc PPO
☐ Employee Only ☐ Employee + Spouse/DP ☐ Employee + Child(ren) ☐ Employee + Family

Waive Coverage ☐ **Do you have other medical coverage?** ☐ Yes ☐ No

---

DENTAL

Please select one option below. You may elect dental coverage even if you do not elect medical coverage. If you select coverage other than Employee Only, you must provide dependent information in the Dependent Section of this form.

Aetna High PPO
☐ Employee Only ☐ Employee + One ☐ Employee + Family
Aetna Low PPO
☐ Employee Only ☐ Employee + One ☐ Employee + Family
Aetna DMO
☐ Employee Only ☐ Employee + One ☐ Employee + Family

Waive Coverage ☐

VISION

Please select one option below. You may elect vision coverage even if you do not elect medical coverage. If you select coverage other than Employee Only, you must provide dependent information in the Dependent Section of this form.

UnitedHealthcare Enhanced Vision
☐ Employee Only ☐ Employee + One ☐ Employee + Family

Waive Coverage ☐

GROUP BASIC LIFE AND AD&D INSURANCE

Group Basic Life and Basic AD&D are both equal to one times your annual benefits salary, up to the plan maximum ($100,000) and are both subject to age reduction. The university pays for your Basic Life and AD&D coverage.

For Associates: The value of university provided life insurance exceeding $50,000 is required to be reported as income by IRS. The Imputed income, based on the IRS Premium Table, will be reported on your W-2 form. If you wish to avoid imputed income, you may waive the value of coverage over $50,000. **If you wish to avoid imputed income by capping your Basic Life insurance, please check here: ☐**

Please Note: If at a later eligibility opportunity, you would like to uncap your Basic Life, you may be required to submit Evidence of Insurability (EOI).

For Scholars: The full value of the university provided life insurance is required to be reported as income by the IRS. The imputed income, based on the IRS Premium Table, will be reported on your Form 1099.

Beneficiaries: *A beneficiary is the person or entity you name to receive the life insurance benefit in the event of your passing. You can update your beneficiaries in the EasyEnroll system. If you do not have access to the EasyEnroll system, please complete the Beneficiary Designation Form posted on the Benefits website and return the form to GW Benefits.*

CONFIRMATION OF ENROLLMENT

Sign and date the confirmation of your enrollment below.

I understand that:

- The information provided above is true and correct to the best of my knowledge.
- The coverage will become effective according to GW's eligibility guidelines following approval of this application.
- Should any material answers or statements contained in this application be untrue, then the coverage may be cancelled and I will be subject to disciplinary action up to and including termination. Further, I may be required to repay payments made in error to me or on my behalf or on behalf of any covered family member as the result of the erroneous information.
- I authorize any provider to forward to the carrier information concerning medical services or supplies provided to me or to any of my family members listed on this application for the purpose of review, investigation or payment of a claim. This authorization is valid for the duration of the coverage.
- A copy of this application is available to the subscriber (or a person authorized to act on his/her behalf) upon request.
- Any person who with intent to defraud, or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive information may be guilty of insurance fraud.

I hereby apply for the group benefit(s) indicated above. I authorize my employer to take deductions from my pay on a pre-tax or post-tax basis as described in the enrollment materials. I understand that my elections cannot be changed or terminated during the plan year and will remain in effect, unless there is a change in my family status called a Qualified Life Event (e.g., marriage, divorce, birth or adoption of child, etc.). Any changes made as a result of a Qualified Life Event must be consistent with the event.

Signature: _____
Date:_____

COMPLETE YOUR ENROLLMENT

You can submit your completed, signed and dated enrollment form to Benefits via email, fax or postal mail.

By email, scan and email to: benefits@gwu.edu

Please Note: if using your GW email, enter the word **ENCRYPT** in the subject line to send the enrollment form and/or supporting documents securely. If using another email, please password-protect your submission or send by fax or postal mail.

By fax, send to (571) 553-8385

By postal mail, send to the following address:
GW Benefits
45155 Research Place, Suite 160
Ashburn, VA 20147