MISSISSIPPI STATE UNIVERSITY
Human Resources Department
McArthur Hall Room 150
P.O. Box 9603 Mississippi State, MS 39762
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BENEFIT/ENROLLMENT CHANGE FORM

HUMAN RESOUCES ONLY: Entered By: _____ Date: _____

Date of Hire:	University ID:
Status: ☐ 9-Month ☐ 12-Month	
Select One:	
☐ New Hire	☐ Legal Marriage/Divorce
☐ Birth/Adoption/Foster Care	
☐ Ineligible Dependent	☐ Open Enrollment
☐ Qualified Medical Child Support Order	
☐ Other Status Change: _____	
Date of Qualifying Event: _____	

Employee Name:	
Address:	
City/State/Zip:	
Home Phone:	Work Phone:
Email Address:	
SSN:	Date of Birth:
Gender: ☐ Male ☐ Female ☐ Undeclared	Marital Status: _____
Is your spouse employed by Mississippi State University? ☐ No ☐ Yes Provide name: _____	

University employees are paid twice a month. Premium deductions for 12-month employees occur over 24 pay periods. 9-month faculty members can choose to have deductions occur over 24 pay periods or 18 pay periods. Pay Mode: Semi-Monthly

Spouse/Dependent Information - *List all dependents you wish to cover or drop from the insurance plans you have selected. Check all benefits that apply.*

Name (Last, First, MI) (Current Legal Name Only)	Social Security Number	M/F	Birth Date	Relationship	Disabled Dependent (yes/no)	Add/Drop/Change	Dental	Vision	UNUM Life and AD&D
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

Dental – Delta Dental

Section 125 Cafeteria Plan
Group # 25-01125

	Employee Only Semi-Monthly Rates	Family Semi-Monthly Rates
Low Plan (0002)	☐ $14.41	☐ $30.07
High Plan (0001)	☐ $20.79	☐ $43.25

Are you or your family member(s) currently covered under another dental plan? ☐ Yes ☐ No

If yes, provide the name of the participant(s) with other coverage: _____

☐ **Waive Coverage**

FOR HUMAN RESOURCES ONLY

Effective Date:_____

Vision – Davis Vision

Section 125 Cafeteria Plan
Group # 7870

	Semi-Monthly Rates
☐ **Employee Only**	$4.17
☐ **Employee + 1**	$7.48
☐ **Family**	$11.63

☐ **Waive Coverage**

FOR HUMAN RESOURCES ONLY

Effective Date:_____

Supplemental Term Life and AD&D – UNUM - Premiums are withheld 12-month / 9-month

**Guarantee Issue (GI) only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability (EOI) must be provided and UNUM has the right at that time to refuse the request for coverage.*

Employee Life / AD&D Coverage	Spouse Life Coverage	Dependent Child(ren) Life Coverage
Choose from $10,000 to $750,000 in $10,000 increments, up to 5 times your annual wage. **Employee Coverage amounts above $200,000 require an EOI Form* ☐ **Elect Coverage** Tobacco User: ☐ Yes ☐ No (used in the last 12 months) **Amount Requested:** $_____	Get up to $500,000 of coverage in $5,000 increments. Spouse coverage cannot exceed 100% of the employee's coverage. **Amounts above $100,000 require Evidence of insurability.* ☐ **Elect Coverage** Tobacco User: ☐ Yes ☐ No (used in the last 12 months) **Amount Requested:** $_____	Get up to $10,000 of coverage in $2,000 increments. One policy covers all of your children until their 26th birthday. ** The maximum benefit for children live birth to 6 months is $1,000.* ☐ **Elect Coverage** Tobacco User: ☐ Yes ☐ No (used in the last 12 months) **Amount Requested:** $_____
☐ **Waive Coverage**	☐ **Waive Coverage**	☐ **Waive Coverage**

Spouse Name (if coverage is selected)	**Spouse Date of Birth** (if coverage is selected)

Beneficiary Designation: *If you do not designate a beneficiary, the payment of benefits will default to provisions of the contract.

Name (Last Name, First, MI):	Relation to You:	Benefit %:
If the beneficiary(ies) named above are not living, then pay:		

Delayed Effective Date: **Employee:** Insurance will be delayed for Employees not actively at work until the date they return to work. Regularly scheduled vacation time is considered active employment. **Dependent**: Coverage for totally disabled dependents will be delayed until the first of the month following the date the individual is no longer totally disabled.
Policy Limitations and Exclusions: I understand all the policy exclusions and limitations listed in the certificate of coverage. If electing to participate in any of the benefit plans mentioned above, I authorize the required payroll deductions. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that if I cancel/decline participation, I may join the Plan at a specified later date; however, I will be required to provide evidence of insurability at my own expense, and the insurance company may refuse my request. In the event of any variations between this form and the Plan document, the terms of the Plan document will prevail.

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Employee Coverage Amount: $ _____ Semi-Monthly Cost: $ _____ Effective Date: _____	Spouse Coverage Amount: $ _____ Semi-Monthly Cost: $ _____ Effective Date: _____	Coverage Amount: $_____ Semi-Monthly Cost: $ _____ Effective Date: _____

Annual Salary: $ _____

Long-Term Disability (LTD) – UNUM	Premiums are withheld 12-Month / 9-Month

You may elect disability coverage of 25% (Non-Integrated) or 60% (Integrated) of your monthly earnings up to $10,000 per month, until age 65. Benefits are payable after a 90- or 180- day elimination period subject to review by UNUM. *Pre-Existing Limitations may apply.

**Guarantee Issue only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability will be required and UNUM has the right at that time to refuse the request for coverage.*

Plan 1 – 60% integrated benefit with 90 day elimination period: 60% of monthly earnings to a maximum benefit of $10,000 per month.

Plan 2 – 25% non-integrated benefit with 90 day elimination period: 25% of monthly earnings to a maximum benefit of $10,000 per month.

Plan 3 – 60% non-integrated benefit with 180 day elimination period: 60% of monthly earnings to a maximum benefit of $10,000 per month.

Plan 4 – 25% non-integrated benefit with 180 day elimination period: 25% of monthly earnings to a maximum benefit of $10,000 per month.

☐ **I Elect Plan #: _____**

☐ **Waive/Cancel Coverage**

FOR HUMAN RESOURCES ONLY

Base Annual Earnings: $ _____

Position Title: _____

Hours Worked per Week: _____ Effective Date: _____

I acknowledge that I voluntarily and without coercion made elections/waivers as documented on this form. I understand my salary will be reduced by the amount(s) shown on this enrollment form for the eligible benefit options I have elected and since premiums are collected one month in advance, the University will collect premiums in arrears as an additional payroll deduction. If my salary reduction for the elected insurance benefit(s) increases or decreases while this agreement remains in effect, my salary will automatically be adjusted to reflect the change.

PRE-TAX ELECTIONS

I understand that eligible benefits offered by Mississippi State University are available to me through payroll deduction under the Pre-Tax Benefit Plan as provided under Section 125 of the Internal Revenue Code (IRC). I understand that I must complete an application for coverage for each election. Cafeteria Plan elections will be irrevocable for the Plan Year except for modifications due to a qualifying event (divorce, marriage, death of spouse/dependent child, birth/adoption of a child, change of employment status of me or my spouse, cost of coverage/change, HIPAA special enrollment rights, or other event specified by the IRS) provided I complete enrollment paperwork to request the election change and submit to the Human Resources Department no later than 60 days after the date of the qualifying event. Prior to each Plan Year, I will be given the opportunity to change my benefit election(s). If I fail to complete and submit to the Human Resources Department a new election form within the allotted enrollment period, I understand my election will remain the same.

I understand pre-tax elections are not eligible as deductions for federal or state income tax purposes and may reduce social security benefits. My employer may reduce or cancel the amount of my salary reduction or otherwise modify this agreement in order to satisfy certain provisions of the Internal Revenue Code.

I understand my elected benefits will cease upon separation of employment but I will be afforded an opportunity to continue coverage via COBRA for qualifying plans.

If I participate in the dependent care plan, reimbursements cannot exceed the amount incurred during the Plan Year. If I participate in an unreimbursed medical expense plan, I may be reimbursed for qualifying out-of-pocket medical expenses. Claims must be filed with Southern Administrators and Benefit Consultants (SABC) no later than April 15 of the following calendar year.

I understand that privacy statements are available via the University website at www.hrm.msstate.edu/benefits. If I do not have access to the internet, I can request a paper copy from the Human Resources Department. As an employee, I acknowledge that I am the subscriber of coverage, and that the Privacy Policy is also applicable to my spouse and/or my dependents. I also understand I will be reissued the Privacy Statement, as a material modification is made, and every three years, via the University's email system.

This election and salary reduction agreement is subject to the terms of my employer's cafeteria plan document.

EMPLOYEE SIGNATURE: _____ **DATE SIGNED: _____**