Southern Methodist University

Benefits Change Form

SMU ID # ______________________

Name (Last, First, M.I.):

Work Phone: | **Change Effective Date:**

LIFE CHANGE EVENT (√)

___ Marriage
___ Adoption of Child
___ Death of Spouse/DP or Dependent
___ Divorce/Annulment
___ Birth of Child
___ Employment Change - Spouse/DP
___ Newly Eligible DP
___ Commencement of Legal Guardianship
___ Full-time to Part-time (new hours: _____/week)
___ Dissolution of DP
___ Loss of Dependent Eligibility
___ Part-time to Full-time (new hours: _____/week)
___ Other → ____

MEDICAL (Complete the section for the Medical option in which you are currently enrolled)

☐ **SMU Health & Wellness Plan** (PPOs administered by BlueCross BlueShield of Texas)

Current Tier → ___ You Only ___ You + 1 Dependent ___ You + Family

New Tier → ___ You Only ___ You + 1 Dependent ___ You + Family

☐ **Aetna HMO** (If adding a dependent, provide name & ID of the Aetna Primary Care Physician)

Current Tier→ ___ You Only ___ You + 1 Dependent ___ You + Family

New Tier→ ___ You Only ___ You + 1 Dependent ___ You + Family

Dependent ______________________ PCP Name ______________________ PCP ID ______________

Dependent ______________________ PCP Name ______________________ PCP ID ______________

Dependent ______________________ PCP Name ______________________ PCP ID ______________

DENTAL (Aetna) (All participants will be enrolled in the Dental PPO initially but may switch to the DMO by calling Aetna)

Current Tier→ ___ You Only ___ You + 1 Dependent ___ You + Family

New Tier→ ___ You Only ___ You + 1 Dependent ___ You + Family

VISION (Compbenefits)

Choose Tier→ ___ You Only ___ You + 1 Dependent ___ You + Family

Choose Tier→ ___ You Only ___ You + 1 Dependent ___ You + Family

Dependent Change (M=Medical, D=Dental, V=Vision √ appropriate boxes if adding or cancelling dependent coverage)

Name (indicate Add or Cancel next to name)	M	D	V	Relationship	Birthdate	Sex(M/F)	Social Security #

Flexible Spending Accounts (Ceridian)

☐ **Health Care FSA** $ ____________ Enter amount to be deducted for remainder of 2008

☐ **Dependent Care FSA** $ ____________ Enter amount to be deducted for remainder of 2008

Basic Group Life (complete Beneficiary Designation below)

Enrollment in this Plan is automatic and premiums are paid by SMU. The benefit is equal to 150% of Annual Base Salary for Regular Faculty & Staff; $10,000 for Post-Doctoral Fellows.

Supplemental Group Life Insurance (complete Beneficiary Designations below)

Employee Coverage ☐ No ☐ Yes ↓

___ 1 x Salary ___ 2 x Salary ___ 3 x Salary ___ 4 x Salary* ___ 5 x Salary*

*** Subject to Evidence of Insurability**

Spouse/DP Coverage ☐ No ☐ Yes ➔ Spouse/DP Date of Birth __________________

Coverage Amount $__________________ ($50,000, not to exceed 100% of employee election)

Child(ren) Coverage ☐ No ☐ Yes

Accidental Death & Dismemberment (complete Beneficiary Designations below)

Coverage ☐ No ☐ Yes

Principal Sum $_________________ ☐ You Only ☐ Family

Beneficiary Designations

Name (Last, First, M)	Relationship	Birthdate	Basic/Supplemental Life % of Benefit	Basic/Supplemental Life Primary/Contingent	AD&D % of Benefit	AD&D Primary/Contingent

Authorization

I have enrolled in the plans indicated on this form. I authorize Southern Methodist University to adjust my paycheck by the amount of my required contributions for these plans. Deductions will continue for each pay period until this agreement is amended or terminated. I understand that I cannot change my elections until the next annual Open Enrollment or within 31 days of another Life Change Event.

Signature: **Date:**