Case Western Reserve University Postdoctoral Benefits Program

Enrollment Form Completion Instructions

This form may be used for enrollment, changes, cancellation or waiver in the Case Postdoc plans. Enrollment in the Case Postdoc Benefits Program is dependent upon the proper completion of this online enrollment form.

Fields marked with a red diamond are REQUIRED. Please print and keep a copy of the enrollment form for your records.

Section 1. Personal Information:

Please complete all fields with requested information.

- **Date of Birth**: Your date of birth should be month, date, year (MM/DD/YYYY). Example: If your birthday is June 7, 1986, please type "06/07/1986".
- **Social Security Number**: If you do not have a Social Security Number, please enter your seven-digit CWRU employee ID number.
- **Home Address:** Please provide FULL ADDRESS: street number, street name, apartment number (if applicable), CITY, STATE AND ZIP CODE.
- **Postdoc Email Address:** Though not shown as a required field, it is important that we have an email address where we may contact you confirming your enrollment in the plans. If you do not have your own email address, please provide an email address where we may send you an enrollment confirmation. No personal information will be provided in this email.
- **Title:** Please provide your title, as ***Postdoctoral Scholar***, ***or Postdoctoral Fellow***, or whatever title you may have. If there is not enough space, please abbreviate.
- **Effective Date of Coverage:** Your effective date of coverage will be the first day of your appointment.

Section 2. Department Information:

Please complete this section including your **department contact name**, **phone** and **email** and **appointment start date**. If you know the **billing contact** information requested, please provide that as well.

Please check ***Bill Me (Postdoc) Directly*** if you were not appointed through the Office of Postdoctoral Affairs and are paying all of the monthly insurance premiums.

Section 3. Type of Action or Qualifying Event (Check all that apply):

- **New Hire:** Please check this section if you are a new University postdoc; please provide the start date of your appointment in the section provided.

- **Rehire:** If you are returning to Case Western Reserve University after a break in coverage, please check this box and provide the date of rehire in the section provided.
- **Change in Appointment Status:** If your appointment status has changed by a move to another department, please check this area and provide the date the change is effective.
- **Add Eligible Family Member**: Please check this box and provide the date you wish coverage to be effective in order to add your eligible family member. Then, complete Section 5 by selecting ***Enroll*** and providing the family member(s') information.

Domestic Partner Coverage: Please check this box if you wish to add your eligible Domestic Partner to this benefit program. The University requires Domestic Partnership Documents.

Please print and complete these forms, then submit them to**: the Administrative Director of Faculty Advancement & Postdoctoral Affairs, Case Western Reserve University, Tomlinson Hall**

Change Personal Data for Eligible Family Member: If there is an address change, name change, addition of a Social Security Number, or any other change in personal data for an eligible enrolled family member, please check this box and supply the information changing in Section 5. Please put the date the change would be effective in the date field. If the address is changing, please start the address field in Section 1 with ***Change:*** and complete with the new address.

Delete Family Member: Please check this box to delete a family member from coverage. Supply the date the deletion should be effective and select the appropriate reason from the drop-down menu. Specify the family member in Section 5 by clicking ***Delete*** by their name(s).

Section 3a. Opt-Out of Coverage (Waiver):

The Case Postdoctoral Benefit Program is a comprehensive, "bundled" benefit program that requires enrollment in all plans: Medical, Dental, Vision, Life insurance and Employee Assistance Program.

If you wish to decline coverage for this program, please check this box. Please also provide the reason for waiving the coverage in the area immediately following by checking either ***Covered by another plan*** or ***Other*** and providing a brief statement.

If you are only waiving coverage for your eligible dependents, please check the box which says, ***I am declining coverage for the following dependents***, check the dependents that apply and provide the reason in the area below.

Section 4: Benefits Elections:

Because the CWRU benefits are "bundled" – you receive all lines of coverage (medical, dental, vision, life insurance and employee assistance program) when you enroll. There is only ONE decision that needs to be made: whether to enroll in the Aetna Health Network Only (HNO) Plan OR the Aetna Open Access Managed Choice Point of Service (OAMC/POS) Plan.

- **Click "YES" in Section 4a.** If you wish for you and your eligible family members to be enrolled in the Aetna Health Network Only (HNO) Plan.

  OR

- **Click "YES" in Section 4b.** If you wish for you and your eligible family members to be enrolled in the Aetna Open Access Managed Choice Point of Service (OAMC/POS) Plan.

Section 5. Eligible Family Members to be Covered:

Your Qualifying Dependents

Benefits coverage is available not just for you but for qualifying family members as well. Qualifying family members include:

- your spouse or equivalent (domestic partner),
- children under age 26 and
- unmarried children of any age if they are mentally or physically incapable of supporting themselves.

Please check the desired action, either Enroll or Delete, then list those individuals for whom you wish coverage or for whom you wish to delete coverage.

Currently Disabled: If you or an eligible dependent are currently disabled, please check this box.

Life Insurance Beneficiary Instructions:

Member/Employee Information

- Life insurance is made available to the CWRU postdoc employee only, not for their dependents
- Please fill out your name, and full address

Beneficiaries: Loved ones who will receive your life insurance money in the event of a tragedy/ your untimely death. This can be your spouse, mother, father, sister, brother, aunt, uncle, best friend, significant other, children. Please note: if you name your children as your life insurance beneficiary – please also include the name and contact information of an ADULT who will manage your child's affairs in your absence.

- **PRIMARY** – This is the first person/people who will receive your life insurance money in the event of a tragedy/ your untimely death.
- **CONTINGENT** – this is the person/people who will receive your life insurance money in the event that your primary beneficiaries are no longer available.

a. Please provide complete contact information for all primary and contingent beneficiaries. Think: If something bad happened to me, how would the CWRU and Gallagher Benefit Services reach my loved ones?

b. If, for example, the best way to reach your loved ones is by email, please include that, even though it is not a required field on the form.

c. You can have as many beneficiaries as you wish. If you wish to name more than two people, please provide the full names, addresses, dates of birth, phone number, relationship and percentage of benefits on a separate sheet.

d. Please include the percentage of the benefit that each beneficiary should receive. If this information is not provided, it is assumed that the life insurance benefit will be split evenly between all primary beneficiaries listed.

Signature: Please initial this section and date your life insurance beneficiary form.

Please note: this form can be updated as frequently as you wish as your situation changes.

Terms and Conditions:

Please read confirm you have read this section.

Gallagher Privacy Notice of Privacy Policy and Insurance Information Practices: This form provides information about how we handle your non- public personal and health information.

Submit and Create Printable Enrollment Form: When you have completed all of the fields on the enrollment form, click here to submit the form to the secure enrollment website and to also create an Acrobat Reader file (PDF) that you can print and keep as your record of enrollment should eligibility verification be required.

Please allow 4-5 business days for your enrollment to be processed. You will receive a confirmation email when your enrollment is complete. If you require any assistance in completing the enrollment form, please call the Case-PBP Customer Service line at 1-949-317-5917 or email UniversityServices.GBS.casepbp@ajg.com.