Case Western Reserve University
Postdoctoral Benefits Program (Case-PBP)

Enrollment Form Completion Instructions

This form may be used for enrollment, change, cancellation or waiver in the Case-PBP plans. Please follow these instructions carefully. Enrollment in the Case-PBP is dependent upon the proper completion of this online enrollment form. Fields marked with ◆ are required. Please print and keep a copy of the enrollment form as your confirmation.

Section 1. Personal Information:
Please complete all fields with requested information.

Date of Birth: Your date of birth should be shown with the month first, then day followed by year. Example: If your birthday is June 7th, 1976, please type "06/07/1976".

Social Security Number: If you do not have a Social Security Number, leave this box blank.

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 e-mail address, please provide an e-mail address where we may send you an enrollment confirmation. No personal information will be provided in this email; only confirmation, or reasons for non-confirmation, of your enrollment.

Title: Please provide your title, as ***Postdoctoral Scholar***, ***Research Associate***, 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 either: 1) The first of the month following your official appointment date (i.e., your appointment is January 6th, then your coverage effective date for all plans would be February 1st); or 2) If your appointment happens to be the 1st of the month, then your effective date will be that same date (your appointment is February 1st, then your coverage effective date is February 1st.).

Section 2. Department Information:
Please complete this section including your **department contact name**, **phone** and **e-mail** and **appointment or fellowship 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 a portion or all of the insurance premiums associated with this

program. You will receive a monthly bill for those premiums via the email address provided on your enrollment form.

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

New Hire: Please check this section if you are a new University employee and provide the 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**: Diana Fox, Office of Postdoctoral Affairs, School of Graduate Studies, Case Western Reserve University, Tomlinson Hall 215, 10900 Euclid Ave., Cleveland, Ohio 44106-7027.**

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-PBP is a comprehensive benefit program that requires enrollment in all plans: Medical, Dental, Vision and Life. Please review the rates under the Enrollment section of this website.

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 4a. If you wish for you and your eligible family members to be enrolled in the Aetna HNO Plan, please check '*Yes*' so that you and your family members will be enrolled in all of the appropriate program plans.

Section 4b. If you wish for you and your eligible family members to be enrolled in the Aetna OAMC POS Plan, please check *'Yes'*, so that you and your family members will be enrolled in all of the appropriate program plans.

Section 5. Eligible Family Members to be Covered:
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.

Terms and Conditions:

Please read this section carefully for valuable information regarding the Case-PBP.

General Notice of COBRA Continuation Rights: Please read this form carefully as it briefly describes your rights under COBRA. Once you have read the form, please click 'Yes' to be able to submit and print your enrollment form. By clicking 'Yes' you are also certifying that any enrolling adult dependents have been provided a copy of this form. If you have any questions concerning COBRA, please call our Case-PBP COBRA department at 1-877-559-9922 ext. 404.

Insurance Carrier Privacy Notice: Please read this form carefully as it describes how the insurance carriers will handle personal health information providing benefit plans for the Case-PBP. Once you have read the form, please click 'Yes' to be able to submit and print your enrollment form.

Required Notice of the Insurance (Healthcare) Marketplace: It is required that you are notified of the availability of health insurance through the Federal Health Insurance Marketplace (Exchange). The Notice does not confirm that you are eligible for the insurance offered, but notifies you of the existence of the Marketplace. Once you have read the Notice, please click *'Yes'*. By clicking '*Yes'*, you confirm that you have read and understand the content of the Notice.

Garnett-Powers' & Associates 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.

If you enroll Monday through Thursday during normal business hours, you will receive an e-mail confirmation of your enrollment within approximately 24 hours. If you enroll over the weekend, please allow an additional day for enrollment processing and confirmation. If you require any assistance in completing the enrollment form, please call the Case-PBP Customer Service line at 1-800-315-4550 or email casepbp@garnett- powers.com.