SUNY WESTCHESTER COMMUNITY COLLEGE

WESTCHESTER COMMUNITY COLLEGE BENEFITS ENROLLMENT/CHANGE FORM (UMR)

Please complete form and return to:
Human Resources Department:
75 Grasslands Rd Admin. Bldg. B42
Valhalla, NY 10595
Telephone: 914.606.8592
Fax: 914.606.7838

EMPLOYEE SECTION A

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY & STATE	ZIP CODE

DATE OF BIRTH	SEX	CELL PHONE	HOME PHONE	WORK PHONE	EMAIL ADDRESS
/ /	□ MALE □ FEMALE	( )	( )	( )	

MARITAL STATUS	DATE OF MARRIAGE	DATE OF DIVORCE	DATE OF DOMESTIC PARTNERSHIP
□ MARRIED □ DIVORCED □ WIDOWED □ SINGLE □ LEGALLY SEPARATED □ DOMESTIC PARTNER	/ /	/ /	/ /

ARE YOU PRESENTLY RETIRED OR EMPLOYED ELSEWHERE? □ YES □ NO	
DO YOU HAVE OTHER GROUP HEALTH, DENTAL, ETC. INSURANCE FROM A PREVIOUS EMPLOYER OR ELSEWHERE? □ YES □ NO	NAME OF PREVIOUS EMPLOYER AND/OR OTHER INSURANCE

MEDICARE STATUS	PART B EFFECTIVE DATE:
DO YOU HAVE OR ARE YOU ELIGIBILE FOR MEDICARE DUE TO DISABILITY OR ESRD □ YES □ NO	

EMPLOYEE SECTION B

PLEASE MAKE YOUR BENEFIT SELECTIONS BELOW CHECK ONE BOX FOR EACH LINE

		BENEFITS OFFICE COMPLETE	
HEALTH PLAN TYPE	□ WCC HEALTH PLAN-UMR (UMR RETIREES ONLY)		
COVERAGE TYPE	□ INDIVIDUAL □ FAMILY □ WAIVE COVERAGE	EFFECTIVE DATE	/ /
DENTAL PLAN	□ INDIVIDU □ WAIVE COVERAGE	EFFECTIVE DATE	/ /

ENROLLMENT ACKNOWLEDGEMENT ***: I certify that all the above information is correct. If my dependent or marital status changes, I will notify Westchester Community College within 30 days of the change. Any intentional misrepresentation of information may result in immediate termination of benefits and/or disciplinary action. I understand that I may not change the coverage elections until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.***

I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

Employee Signature: _____ *Date:* _____

WAIVER OF COVERAGE ACKNOWLEDGEMENT ***: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes. If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPAA Special Enrollment because of loss of that coverage. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage:***

I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage. For specific plan language, contact Human Resources.

CERTIFICATION: I freely and voluntarily waive all coverage noted above.

Employee Signature: _____ *Date:* _____

BENEFITS OFFICE COMPLETE

EMPLOYMENT STATUS	STATUS EFFECTIVE DATE	AGENCY/DEPARTMENT	JOB TITLE	DATE OF HIRE
□ ACTIVE □ COBRA □ RET. LWOP □ RETIRED □ DISABLED □ DEPENDENT SURVIVOR □ WORKING SPOUSE RULE APPLIES	/ /			/ /

Employer's Representative: _____ *Date:* _____

SPOUSE / DOMESTIC PARTNER

SPOUSE / DOMESTIC PARTNER LAST NAME		SPOUSE / DOMESTIC PARTNER FIRST NAME		MIDDLE INITIAL	SOCIAL SECURITY NUMBER
					/ /
DATE OF BIRTH	**SEX**	**EMPLOYED**	**DISABLED**	**DATE OF DISABILITY**	**HMO PCP**
	□ MALE □ FEMALE	□ YES □ NO	□ YES □ NO		
NAME OF EMPLOYER		DOES YOUR SPOUSE /DOMESTIC PARTNER HAVE OTHER GROUP HEALTH, DENTAL OR VISION COVERAGE □ YES □ NO			
TYPE OF BENEFITS	**NAME OF CARRIER / ADMINISTRATOR**	**COVERAGE**		**EFFECTIVE DATE**	**CANCELLATION DATE**
HEALTH		□ INDIVIDUAL □ FAMILY		/ /	/ /
DENTAL		□ INDIVIDUAL □ FAMILY		/ /	/ /
MEDICARE	**MEDICARE NUMBER**	**EFFECTIVE DATE PART A**		**EFFECTIVE DATE PART B**	
□ YES □ NO		/ /		/ /	

DEPENDENTS

(01) LAST NAME (IF DIFFERENT)		FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	SOCIAL SECURITY NUMBER
					/ /
DATE OF BIRTH	**SEX**	**EMPLOYED FULL-TIME**	**DISABLED**	**DATE DISABLED**	**MEDICARE**
	□ MALE □ FEMALE	□ YES □ NO	□ YES □ NO	/ /	□ YES □ NO
Student Full-Time	**College Name**		**HMO Primary Physician Code**		
☐ Yes ☐ No					

(02) LAST NAME (IF DIFFERENT)		FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	SOCIAL SECURITY NUMBER
					/ /
DATE OF BIRTH	**SEX**	**EMPLOYED FULL-TIME**	**DISABLED**	**DATE DISABLED**	**MEDICARE**
	□ MALE □ FEMALE	□ YES □ NO	□ YES □ NO	/ /	□ YES □ NO
Student Full-Time	**College Name**		**HMO Primary Physician Code**		
☐ Yes ☐ No					

(03) LAST NAME (IF DIFFERENT)		FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	SOCIAL SECURITY NUMBER
					/ /
DATE OF BIRTH	**SEX**	**EMPLOYED FULL-TIME**	**DISABLED**	**DATE DISABLED**	**MEDICARE**
	□ MALE □ FEMALE	□ YES □ NO	□ YES □ NO	/ /	□ YES □ NO
Student Full-Time	**College Name**		**HMO Primary Physician Code**		
☐ Yes ☐ No