# Benefits Election

**Related Policy:** Layoff Severance Program for Civil Service and Union Represented Employees

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| --- | --- | --- | --- |
| Name: | | Date of Birth: | Employee ID: |
| Spouse Name: | | Date of Birth: | |
| Street Address: | | | |
| City: | State: | | Zip: |
| Phone (with area code): | | Last Day of Employment: | |

**I. MEDICAL & DENTAL BENEFITS (check one of the following options)**

I have less than three years of service, and I understand that I am eligible for COBRA continuation only.

I have three or more years of service, and I wish to elect COBRA continuation for up to 18 months, foregoing any University contribution under this Layoff Severance Program.

I have three or more years of service, and I wish to elect medical and dental benefits under the Layoff Severance Program. I understand that the University will contribute to the cost of my benefits based on my years of continuous service. I understand that the contribution will be based on my level of coverage (employee-only or tier of family coverage), work location, and permanent residence as of my last day of employment. I also understand that if the above contribution is for less than 18 months, I may continue coverage, payments would be payable to 121 Benefits / BRI for the balance of the 18 months at my own expense.

I am age 65 or over:

Do you have or have you applied for Medicare?  Yes  No

If yes, please indicate:  Part A  Part B

Does your spouse have or have they applied for Medicare?  Yes  No

If yes, please indicate:  Part A  Part B

I DO NOT wish to continue any medical and dental coverage.

II. Continuation of Group Life Insurance and Health Care Flexible Spending Account

**Note:** This form is used to enroll in medical and dental only. In order to reinstate group life insurance and/or a Health Care Flexible Spending Account, follow instructions provided in the COBRA notice, which will be issued via U.S. mail from 121 Benefits/BRI. If you’d like to continue University dental and medical benefits, do not elect those benefits on the COBRA notice.

Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_