



2010 NYU Benefits Enrollment Form

For Adjunct Faculty (Object Code 112)
Covered by the Collective Bargaining Agreement
between New York University and the UAW

INSTRUCTIONS

NYU offers group health insurance coverage to qualified adjunct faculty who have met the specified service requirements as stated in the Collective Bargaining Agreement between New York University and the UAW.

Please complete, sign, and returned this form, along with any accompanying documentation to:

The NYU Benefits Office
7 East 12th Street, 2nd Floor (Campus Mail Code: 8923)
New York, NY 10003-4475
Email: benefits@nyu.edu Telephone: 212-998-1270 Fax: 212-995-4050

EMPLOYEE INFORMATION (THIS SECTION MUST ALWAYS BE COMPLETED IN FULL)

▶	▶	▶
NAME	UNIVERSITY ID	NYU PHONE NUMBER
▶	▶	▶
DATE OF BIRTH	DATE OF HIRE	NYU EMAIL

ENROLLMENT TYPE:

- New Enrollment:
You must submit your elections before the end of the Open Enrollment period, or within 31 days following your initial eligibility date.
- Status Change: Type of status change: _____ Date of change: _____
If you have a status change, your elections must be consistent with the change that occurred and this form must be submitted within **31** days of the qualifying event.

ELECTION FOR MEDICAL COVERAGE

I want to be covered by the following medical plan (check one box):

- Aetna HMO** I want to *wave* medical coverage
- Oxford Freedom HMO

Select the level of medical coverage you want below (check one box):

- Single (self only) Employee + Child(ren) (self plus one or more eligible children)
- Employee + Spouse/Partner Family (self plus spouse/partner and one or more eligible children)

Once you have enrolled, you will receive a package of 12 monthly invoices from the Employee Benefit Plan Administration, Inc. (EBPA), the billing administrator for NYU. To keep your coverage in effect, payments must be received by EBPA each month before the due date indicated on each invoice. *If you do not make payments on time, your coverage will end on the last day of the month for which you paid for coverage.*

DEPENDENT COVERAGE

If you are selecting two-person or family coverage, list the dependents you want to cover. Be sure to read the important note below about submitting proof of relationship for your dependents.

NAME	RELATIONSHIP	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY NUMBER	MEDICAL
		/ /	- -	<input type="checkbox"/> YES <input type="checkbox"/> NO
		/ /	- -	<input type="checkbox"/> YES <input type="checkbox"/> NO
		/ /	- -	<input type="checkbox"/> YES <input type="checkbox"/> NO
		/ /	- -	<input type="checkbox"/> YES <input type="checkbox"/> NO

Important note applicable to dependent enrollment in an NYU medical plan:

If you have not previously submitted proof of relationship for the dependents you plan to cover, you will need to attach to this form copies of the required documentation: birth certificate, adoption papers, court order of guardianship/custody, marriage certificate or your approved NYU Domestic Partner Registration form.

AUTHORIZATION

By enrolling in one of the health plans shown above, I certify to NYU that I am not eligible for group health insurance through employment elsewhere.

I understand that if I do not enroll in the NYU group health insurance when I am eligible, or if I allow my NYU group health coverage to lapse, I cannot re-enroll in any of the NYU health care options, provided that I am eligible, until the next open enrollment period, or unless I have a change in family status.

I further understand that if I do not make payments on time, my coverage will end on the last day of the month for which I paid for coverage.

▶
▶
 SIGNATURE DATE

If you need assistance in completing this form, please e-mail the Benefits Office at benefits@nyu.edu, or call 212-998-1270 to speak with a Benefits Specialist. You may also make an appointment with a Benefits Specialist at the NYU Benefits Office at 7 East 12th Street. Hours: 9 a.m. to 5 p.m., Monday through Friday.

FOR BENEFITS OFFICE USE ONLY: _____ DATE ENTERED _____ VERIFIED _____