

Read the Enrollment Guide for information about benefit plan options, costs, requirements and tax implications.

Employee Information — Please print or type				
Last Name	First Name	M.I.	Andrew ID	
Street Address		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (Month/Day/Year)	
City	State	Zip	Work Phone	Home Phone
Email Address				

Reason for Enrollment/Change	
<p>Changes to benefit enrollments during the year must be due to certain changes in employment, family or work status.* No other changes are permitted until the annual Open Enrollment period.</p>	
<p>DATE OF EMPLOYMENT/CHANGE: _____</p> <p><input type="checkbox"/> New Employee/Open Enrollment</p> <p><input type="checkbox"/> Marriage*</p> <p><input type="checkbox"/> Domestic partner relationship established*</p> <p><input type="checkbox"/> Divorce*</p> <p><input type="checkbox"/> Domestic partner relationship terminated*</p> <p><input type="checkbox"/> Death of spouse/domestic partner/dependent*</p> <p><input type="checkbox"/> Birth/adoption of dependent*</p>	<p><input type="checkbox"/> Commencement of dependent's or spouse's/domestic partner's coverage under another plan*</p> <p><input type="checkbox"/> Termination of dependent's or spouse's/domestic partner's coverage under another plan*</p> <p><input type="checkbox"/> Return from leave</p> <p><input type="checkbox"/> Other (subject to approval): _____ _____</p>
<p>*Documentation may be required. Contact HR Services to obtain further information.</p>	

Medical Election	
<p>I elect the following medical plan:</p> <p><input type="checkbox"/> Aetna HMO</p> <p><input type="checkbox"/> Waive medical coverage</p>	<p>I elect the following level of coverage:</p> <p><input type="checkbox"/> Employee</p> <p><input type="checkbox"/> Employee and Child</p> <p><input type="checkbox"/> Employee and Children</p> <p><input type="checkbox"/> Employee and Spouse</p> <p><input type="checkbox"/> Employee and Domestic Partner (DP)</p> <p><input type="checkbox"/> Family (employee, spouse, children)</p> <p><input type="checkbox"/> Family (employee, DP, children)</p>

Group Term Life Insurance	
<p>I elect the following amount of Group Term Life Insurance:</p> <p><input type="checkbox"/> Basic Life Insurance (no cost)</p> <p><input type="checkbox"/> Basic + Optional Life Insurance</p> <p><i>You must elect a level of Group Term Life Insurance. You cannot waive the coverage.</i></p>	<p>Basic Life Insurance coverage of 1½ times salary or \$12,000, whichever is greater, is provided by Carnegie Mellon University at no cost to you. You may elect to purchase additional Optional Life Insurance coverage at levels based on your salary and age. Please refer to the L95 Enrollment Guide for more information.</p>

Employee and Dependent Information				
If electing a level of coverage that includes spouse/domestic partner or children, complete this section. If covering more than four dependent children, request an additional form from HR Services.				
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Activity: <input type="checkbox"/> Add to Medical <input type="checkbox"/> Delete from Medical		Date of Birth (Month/Day/Year)		
Child 1	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Activity: <input type="checkbox"/> Add to Medical <input type="checkbox"/> Delete from Medical		Date of Birth (Month/Day/Year)		
Child 2	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Activity: <input type="checkbox"/> Add to Medical <input type="checkbox"/> Delete from Medical		Date of Birth (Month/Day/Year)		
Child 3	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Activity: <input type="checkbox"/> Add to Medical <input type="checkbox"/> Delete from Medical		Date of Birth (Month/Day/Year)		
Child 4	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Activity: <input type="checkbox"/> Add to Medical <input type="checkbox"/> Delete from Medical		Date of Birth (Month/Day/Year)		
Employee Signature				
I acknowledge and agree that the benefits I have elected are subject to the provisions of the Carnegie Mellon University Benefit Plan and the terms and conditions of each feature under that Plan. I agree that my compensation will be reduced by the amount of any required contributions for the benefits that I have elected under the Plan and that such salary reductions will continue for each pay period until my election is amended or terminated as permitted under the Plan. I acknowledge that I have access to the Plan documents through Carnegie Mellon’s Human Resources website. I affirmatively represent that all information provided is true and correct.				
_____ Signature			_____ Date	

Return to: HR Services, UTDC, 1st Floor, 4516 Henry Street

Questions? 412-268-4600 or hr-help@andrew.cmu.edu