Tulane University School of Medicine
Resident Enrollment Form

Please fill out both side of this enrollment form. Please print legibly.

Name _____ ☐ Male ☐ Female Date of Birth _____

Address _____ Date of Hire _____

City, State, ZIP _____ Marital Status _____

Social Security Number _____ Phone _____

New Enrollment/Additions (circle one): New Hire Annual Enrollment Reinstatement Birth Marriage Adoption Loss of Other Coverage Court-Ordered Dependent Other (describe) _____ Requested Effective Date _____

Cancellations (circle one): Other Coverage Divorce Dependent Reached Max Age Other (describe) _____ Date of Cancellation _____

Choose your benefits carefully. Per IRS regulations, changes to pre-tax benefit options cannot be made during the year unless you experience a qualifying event.

Medical/Rx Plan – Low Option (UnitedHealthcare) Choice Plus Plan LA1

Type of Coverage	*Monthly Cost*	*Declination of Coverage*
Resident Only	☐ $0	☐ I am declining this medical coverage.
Resident + Spouse	☐ $224.28	
Resident + Child(ren)	☐ $69.65	
Full Family	☐ $344.64	

Medical/Rx Plan – High Option (UnitedHealthcare) Choice Plus Plan LAX

Type of Coverage	*Monthly Cost*	*Declination of Coverage*
Resident Only	☐ $0	☐ I am declining this medical coverage.
Resident + Spouse	☐ $355.66	
Resident + Child(ren)	☐ $241.00	
Full Family	☐ $574.96	

Dental Plan – Low Option (Guardian) G-513680

Type of Coverage	*Monthly Cost*	*Declination of Coverage*
Resident Only	☐ $15.04	☐ I am declining this dental coverage.
Resident + Spouse	☐ $31.55	
Resident + Child(ren)	☐ $34.55	
Full Family	☐ $51.08	

Dental Plan – High Option (Guardian) G-513680

Type of Coverage	*Monthly Cost*	*Declination of Coverage*
Resident Only	☐ $22.40	☐ I am declining this dental coverage.
Resident + Spouse	☐ $47.01	
Resident + Child(ren)	☐ $51.49	
Full Family	☐ $76.10	

Vision Plan (Guardian) G-513680

Type of Coverage	*Monthly Cost*	*Declination of Coverage*
Resident Only	☐ $5.98	☐ I am declining this vision coverage.
Resident + Spouse	☐ $11.01	
Resident + Child(ren)	☐ $11.53	
Full Family	☐ $18.07	

Basic Life/AD&D and Long-Term Disability

These programs are provided at no cost to you.

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FOR EMPLOYER USE ONLY! ☐ New Enrollment Date of Hire_____ Effective Date _____
☐ Change Qualifying Event Date_____Effective Date_____ ☐ Termination Term. Date_____Effective Date

Supplemental Life/AD&D

If coverage was initially declined at the time you were newly eligible, if you requested an amount over the G.I. maximum, or you are electing to increase your current coverage, an Evidence of Insurability form will need to be completed and coverage approved before it will become effective. If I have life insurance coverage with Hartford Life and Accident Insurance Company, I understand and agree that the life insurance benefit(s) reduce at a specified age(s) stated in the policy. If I have disability income coverage with Hartford Life and Accident Insurance Company, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

Resident Coverage Requested (limited to $500,000)

☐ Increments of $10,000. Amount requested $_____

☐ Spouse Coverage Requested (limited to $250,000 or 50% of resident coverage)
Amount requested $_____

☐ Child(ren) Coverage Requested
$1,000, $5,000, or $10,000 at $0.171 per $1,000 unit

☐ I decline this coverage.

☐ Resident AD&D, increments of $10,000. Amount requested $_____

Rates Table (per $1,000 of coverage)

Age	Resident OR Spouse
Less than 25	$0.08
25-29	$0.091
30-34	$0.091
35-39	$0.114
40-44	$0.137
45-49	$0.228
50-54	$0.331
55-59	$0.65
60-64	$0.901
65-69	$1.505
70-74	$2.85
75 or over	$14.79
AD&D	$0.03

Guarantee Issue when enrolling during your initial eligibility period: • You $150,000 • Your Spouse $50,000 • Your Children $10,000. For any election over the Guaranteed Issue amount of $50,000 for your spouse, an Evidence of Insurability form will need to be submitted for approval.

Your Dependents List all of the dependents you will cover.

Dependents over the age of 19 will require proof of full-time student status for medical, dental, and vision.

Legally Married Spouse/Dependent's Name(s)	Sex M/F	Relationship	Birthdate (mm/dd/yy)	Social Security Number	Coverage Desired	Enroll/ Cancel	Age
					☐ Medical ☐ Dental ☐ Vision	☐ Enroll ☐ Cancel	
					☐ Medical ☐ Dental ☐ Vision	☐ Enroll ☐ Cancel	
					☐ Medical ☐ Dental ☐ Vision	☐ Enroll ☐ Cancel	
					☐ Medical ☐ Dental ☐ Vision	☐ Enroll ☐ Cancel	

Your Beneficiaries List all of your beneficiary designations for basic life, AD&D, and supplemental life benefits.

Legally Married Spouse/Dependent's Name(s)	Relationship	Social Security Number	Primary/ Contingent	%	Basic Life/ AD&D	Supplemental Life
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

Authorization

Please read and sign the following statement for your coverage to take effect: Please enroll me in the benefit(s) I have elected and make the necessary payroll deductions from my pay. I have read and understand the enrollment form and its explanatory material. I understand that this election of benefits is binding on me and cannot be marked or modified until the next enrollment period unless I have a family status change as defined by the flexible benefits plan. I agree that if I do not elect medical coverage for myself or my dependents, I will not hold my employer liable for any material expense incurred by the dependents or me. WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison. I declare that I am actively at work on the date of this enrollment form and that the information furnished to the best of my knowledge and belief is true, correct, and complete.

An employee's decision to elect medical, dental, or vision or not elect medical, dental, or vision must be retained until the plan's next Open Enrollment period. If the employee elects not to enroll in the medical, dental, or vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.

- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

_____

Name (please print)

_____

Signature

_____

Social Security Number

_____

Date