THE UNIVERSITY OF
SCRANTON
A JESUIT UNIVERSITY

Office of Human Resources

Change in Marital Status
Add or Remove a Spouse/Dependent Packet

Benefit forms need to be completed when a benefit eligible staff or faculty member changes address, marital status, and/or benefit plan enrollment. These forms need to be completed and returned to the Human Resources office within 30 days of the qualifying event and/or status change.

- ✓ Qualifying Events: A change in your situation — like getting married, having a baby, or losing health coverage — that can allow benefit plan changes outside the yearly Open Enrollment Period
- ✓ Verifying dependents: [illegible] University Benefits documentation [illegible] required

You only need to complete the forms that pertain to you.

Forms to be returned for a marital status change, including adding or removing a spouse or dependent:

- Office of Human Resources Data Change Form
- W-4 (only if you wish to change your federal withholding)
- Residency Certification
- Highmark Enrollment
  - Only complete section 1 *Employee Information*; complete section 2 *Dependent Information to* add/remove a spouse or dependent
- United Concordia Dental Enrollment
  - [illegible] add/remove a spouse or dependent
- Retirement Vendor Information Change Form
  - Only complete the form for the vendor you have an account with
- Medical/Dental Enrollment Option Form
- TIAA or Transamerica Beneficiary Designation Form
  - Only complete the form for the vendor you have an account with and only if you are choosing to update the beneficiary
- Cigna Life Insurance Beneficiary Designation Form *(not in the packet, must be opened separately)*
  - Only complete the form for the vendor you have an account with and only if you are choosing to update the beneficiary

All forms are available in the Office of Human Resources, St. Thomas Hall room 100

[illegible]

O ce of Human Resources

Data Change Form

Name: _____ Royal ID #: _____

E ec ve Date of Change: _____

Check the appropriate box(es) to indicate a change to your personal informa on as indicated below:

Name: _____
(Please provide suppor ng documenta on i.e., marriage cer ficate, divorce decree, etc.)

Physical Address:_____ If di erent, provide mailing address:
_____ _____
_____ _____
_____ _____

Telephone Number: _____
Home Cell

Marital Status: (Please provide suppor ng documenta on i.e., marriage cer ficate, divorce decree, etc.)
Single Married Widowed Divorced

Add Remove the following spouse/dependent(s):
(Please provide suppor ng documenta on, i.e., l'

Highmark
UCCI
COBRA

Received in HR: _____
Date Completed: _____

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to .

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest

CLGS-32-6 (6-13)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

EMPLOYEE INFORMATION — RESIDENCE LOCATION

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN BLUE OR BLACK INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

D D C D

First Name MI Last Name

Relationship to You? ❑ Child
☐ Step-child ☐ Adopted* ❑ Other*

Social Security Number *(If no SS#, write N/A)*

Gender
❑ Male ❑ Female

Date of Birth *(Month/Day/Year)* Age
/ /

Product Selection(s):
☐ Medical ☐ Vision ❑

Dependent Status if Age 26 or Older

☐ ☐

D D C D

☐ ☐ ☐

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to su
eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

☐ ☐ ☐

☐ ☐ ☐

IV OTHER HEALTH INSURANCE COVERAGE

- C

C		D / /	
D B / /			❑ Active ❑ Retired Date of Retirement: / /

C (B)

D	C	D			C (✓)		C	C ?	
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease		
								❑ Yes	❑ No
								❑ Yes	❑ No
								❑ Yes	❑ No

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy O ce.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

For Ongoing Enrollment: If adding new employees/contract holders/or dependents to an e isting group, please fa /send Enrollment/Waiver Forms to one of the following addresses:

Fa (800) 290-3301

https://www.enrollmentandbilling@highmark.com

Membership Department
P.O. Bo 535193
Pittsburgh, PA 15253-5193

To find more information about our benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4106.

We do not discriminate on the basis of race, color, national origin, disability, age, se , gender identity, se ual orientation, or health status in the administration of the plan, including enrollment and benefits determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on the back of your Member ID card to request these free services (TTY/TDD users may call 711).

Highmark Blue Cross Blue Shield, First Priority Life Insurance Company (FPLIC) and First Priority Health (FPH) are independent licensees of the Blue Cross and Blue Shield Association.
Insurance may be provided by Highmark Blue Cross Blue Shield, FPLIC or FPH. Health care plans are subject to terms of the benefit agreement.

MEDICAL/DENTAL ENROLLMENT OPTION FORM

I. Premium Conversion Plan

125 participant:

[ ] I wish to participate in the Premium Conversion Plan and make contributions toward the cost of medical and dental insurance premiums with pre-tax dollars. I understand that my compensation will be reduced while this election is in effect and the amount of the reduction will be the amount of the cost of the insurance premiums.

125 non-participant:

[ ] I decline participation in the Premium Conversion Plan. I understand that payment of any medical and dental insurance premiums will be with after-tax dollars.

II. Opt-Out Plan

[ ] I wish to waive medical and dental insurance coverage which the University provides for employees and spouses and/or dependents and hereby certify that medical insurance is provided elsewhere. I understand that except for a life event as defined by the IRS, I will only be allowed to opt back into coverage during the annual open enrollment period.

Name:_____

Date:_____

Signature:_____

TIAA CREF

Financial Services

QUESTIONS?

800 842-2252

tiaa-cref.org 24

IMPORTANT INFORMATION

. tiaa-cref.org

. 800 842-2252.

Did you know that incomplete information can make it difficult for us to find your beneficiaries?

. www.tiaa-cref.org/profile

. www.tiaa-cref.org/beneficiary, . 800 842-2252.

Selecting a Beneficiary

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TIAA CREF

Financial Services

IMPORTANT INFORMATION (C

1. PROVIDE YOUR INFORMATION

2. DESIGNATION TYPE (CHOOSE ONE)

☐ New designation

NOTE:

3. APPLICABLE CONTRACTS

☐

OR

☐

•

•

4. CHOOSING YOUR PRIMARY BENEFICIARY

NOTE: 100%.

OR

1. PRIMARY BENEFICIARY

2. PRIMARY BENEFICIARY

100%.

5. CHOOSE YOUR CONTINGENT BENEFICIARIES

1. CONTINGENT BENEFICIARY

2. CONTINGENT BENEFICIARY

6. YO

7. ADDITIONAL REQUIRE

BENEFICIARY PROVISIONS

1. Effectiveness

ADDITIONAL PROVISIONS

Provision:

Example:

FRAUD WARNING