ADDITIONAL BENEFITS ENROLLMENT FORM
*DOMESTIC PARTNER COVERAGE

THE UNIVERSITY OF UTAH

Name	Empl ID#
Email	Phone

Accidental Death and Dismemberment Insurance

(Combined Insurance Company of America, Policy Number 42713VA)

This optional insurance allows employees to insure themselves and eligible family members against covered accidents in an amount up to $500,000. Dependents covered under this plan are covered only for a specified percentage of the employee's elected coverage. (See Plan Booklet for specific details.) Evidence of insurability is never required to enroll in this coverage. Coverage is effective on the first of the month following the date the enrollment form is submitted to the Benefits Department (or on the date it is submitted if it is the first day of the month).

Coverage amount desired: $_____

Select one of the following options:

[ ] Employee Only Coverage ($.19 per $10,000 of coverage)
[ ] Employee and Family Coverage ($.36 per $10,000 of coverage)
[ ] Waive

Designate at least one Primary and one Contingent Beneficiary (if more than one, state percent of benefit to go to each person):

Primary Beneficiary: _____ Relationship to Employee: _____

Contingent Beneficiary: _____ Relationship to Employee: _____

(Employee is beneficiary for coverage on family members)

Long Term Care Insurance *(CNA Insurance Companies Policy Number 31A9487)*

This optional insurance provides coverage for nursing home, adult day care and home-based care. Coverage is available for an employee, his/her domestic partner, and the parents and grandparents of the employee and domestic partner. I understand that if I enroll during my Initial Enrollment Period (3 months following date of hire or transfer into a position eligible to enroll in this coverage), I will not be required to provide evidence of insurability for coverage on myself. If I wish to enroll after my Initial Enrollment Period, I will be required to apply and provide evidence of insurability. Evidence of insurability is always required for my domestic partner, parents, and grandparents.

If you enroll in Long Term Care Insurance, you must also complete and return a separate application - Rates are in the CNA Long Term Care information packet. Parents and grandparents must complete a different application and are billed directly by the insurance carrier.

I choose to enroll in the Long Term Care Insurance and am enclosing my CNA application form:	[ ] Myself	[ ] Waive
	[ ] My Domestic Partner	[ ] Waive

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I have read and understand the information provided. I agree to the terms of the plans selected with this form.

I certify that my Domestic Partner and I are both over the age of 18; reside together in a permanent residence and have done so for at least six months and will remain members of the same household for the period of coverage; have a serious and committed relationship which we intend to continue indefinitely; are emotionally committed to one another and jointly responsible for the common welfare and financial obligations of our household or one of us is chiefly dependent upon the other for financial assistance; not related in any way that would prohibit legal marriage; and not legally married to anyone else or the partner of anyone else. I acknowledge that if we fail to meet any of these conditions in the future, my Domestic Partner and his/her children will no longer be eligible for coverage under this plan.

I certify the information I have provided on all parts of this form is true and correct. I hereby authorize any payroll deductions of required premiums.

Employee Signature: _____ Date: _____

Benefit Dept Use Only	Entry Date:	Entered By:	QC By:	QC Date: