ROGER WILLIAMS UNIVERSITY and SCHOOL OF LAW
Benefit Election and Waiver Form - ACA Medical Coverage Only

HR USE - Payroll Cycle ☐BS ☐BW ☐LS ☐LB

Name: _____ **RWU ID:** _____

Classification: ☐ Dining ☐ Facilities ☐ Faculty ☐ PSSA ☐ Public Safety
Check **ONLY ONE** *(required)* ☐ RWU Non-Aligned ☐ School of Law ☐ School of Law Faculty

Reason for Form (please select one)
☐ New Hire ☐ Open Enrollment ☐ Status Change ☐ Qualifying Event ☐ Cancellation

Effective Date: _____

- *Benefits are effective the first of the month after your hire date or the date of a qualifying event (except birth/adoption).*
- *Open Enrollment changes are effective July 1st.*

BENEFIT COVERAGE ELECTION & WAIVER OF BENEFIT

MEDICAL Please select your plan and coverage level:

Blue Cross Blue Shield of Rhode Island

Includes Health Reimbursement Account (HRA) Coverage

Blue Choice Value	☐ Individual	☐ Family
(not available for PSO) **Blue Choice**	☐ Individual	☐ Family
(not available for Dining & PSO) **BlueCHiP Flex**	☐ Individual	☐ Family
HealthMate Coast-to-Coast	☐ Individual	☐ Family

WAIVER of COVERAGE(S) Please select your coverage level: ☐ Individual ☐ Family

Payroll Deduction Authorization

1. I understand that my employer or plan sponsor, in accordance with the underwriting guidelines of the carrier, will determine the effective date and termination date of my benefit coverage.
2. I understand that my employee contributions for the benefits I elect are payroll deducted. I authorize the deductions from my paycheck for any benefits plans in which I enroll and understand that the University will deduct any retroactive contributions, as needed.
3. I understand that I am responsible for any benefit deductions. If deductions are not collected through payroll because I did not receive a paycheck, I understand that I must coordinate such payment(s) with the Department of Human Resources.
4. I have the option of changing my elections only during the University's annual open enrollment or within 30 days of a qualified family status change.
5. I am in receipt of information on voluntary benefits.
6. By opting out of medical and/or dental coverage, I attest that myself and any dependent I claim on my taxes have group medical coverage. I understand that group medical coverage does not include coverage through the marketplace (also known as the Exchange) or coverage directly from an insurance company. I accept responsibility for myself and my dependents' medical insurance, including confirming that the other coverage is minimal essential coverage as defined by the Affordable Health Care Act. I also understand that in making this election, my employer is not responsible for any lapse in insurance coverage through my spouse or other entity. Eligibility to enroll later shall be at the University's annual open enrollment or within 30 days of a qualified family status change.
7. I understand that my payroll deductions for benefit elections are **pre-tax**, where applicable. If you would like to have the applicable benefit deductions taken **post-tax**, please submit your request in writing to the Department of Human Resources.
8. I understand that if I elect to cover a domestic partner, certain premiums may not be pre-tax and that the University portion of the premium may be considered taxable income.

By signing below, I certify that I have read and understand the above statements and that all information is true and correct to the best of my knowledge.

_____ _____

Employee Signature Date