



BROWN

BROWN UNIVERSITY YEAR 2010 BENEFITS PROGRAM ENROLLMENT FORM

FILLING OUT YOUR ENROLLMENT FORM...

- To make it easier for you to complete this enrollment form, please refer to your *Year 2010 Benefits Enrollment Decision Guide*. Section 2 of the *Guide* explains what you must do in order to elect your benefits for calendar year 2010.

- When you have completed filling out your Year 2010 Enrollment Form, **sign and date it in Section 8, keep the yellow copy**, and return the white copy to the Benefits Office, Box 1879.

- For coverage to become effective:
 - For open enrollment
 - For first time enrollment
 - For changes due to a qualifying event
- Return your completed form to the Benefits Office:
 - By November 13, 2009
 - Within 31 calendar days after your hire date or the date you become eligible for coverage
 - Within 31 calendar days after the date of the qualifying event (and with required documentation)

- **Remember to retain the yellow, bottom copy** for your files and/or future reference. (If you print your form from your computer, please remember to sign and date it. Be sure to make and retain a copy for your files.)

DEADLINE FOR RESPONSE

PLEASE REMEMBER...



If you are making your benefit elections during the Open Enrollment, please use the secure and convenient **Open Enrollment Online System**.

- The **2010 Open Enrollment is active**, which requires all employees to enroll in order to be covered under any of the University's benefit plans in 2010.

- If you are electing coverage for dependents, you must provide their Social Security numbers for compliance purposes.

- You will need to elect and be approved for a minimum of \$10,000 of employee group term Voluntary Life Insurance coverage in order to insure your spouse, same-sex domestic partner or eligible dependent children.

- If you contribute to your benefits on a **pre-tax** basis and you experience a **Qualifying Event**, you must **notify the Benefits Office in writing and with supporting documentation within 31 calendar days** of the event to be eligible to make changes to your current benefit choices.

- If your student dependent will graduate during calendar year 2010 and **you anticipate decreasing your level of coverage** before the end of the year, you should consider electing health and/or dental insurance coverage on a **post-tax** basis.

- If you are a **newly hired** faculty or staff member, or a bargaining unit employee, and you are electing **dental insurance**, your coverage will become effective the **first of the month following three full months of employment**.



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AS YOU COMPLETE THIS FORM, REFER TO APPROPRIATE SECTIONS OF THE YEAR 2010 DECISION GUIDE AND **PRESS FIRMLY USING INK**. PLEASE KEEP THE YELLOW COPY FOR YOUR RECORDS. IF YOU ARE PRINTING THIS FORM FROM YOUR COMPUTER, PLEASE PRINT AND RETAIN A COPY FOR YOUR RECORDS.

(Check one) Open Enrollment New Hire Other _____

All Shaded Sections: Benefits Use Only

_____ Ben Group _____ Ben %

INIT. DATE

Rec'd by: _____

Entered by: _____

Verified by: _____

SECTION 1: PERSONAL INFORMATION

NAME _____ SEX Male Female

STREET ADDRESS _____ HIRE DATE (___/___/___) BIRTH DATE (___/___/___)

CITY/STATE _____ ZIP _____ TEL. _____ CAMPUS BOX _____ CAMPUS EXT. _____

STATUS Single Married (___ check here if you are electing coverage for a common law spouse*) Same-Sex Domestic Partnership* (If selecting this status, you must fill out additional forms available at the Benefits Office.)
*Carrier(s) may require additional information.

Please check preferred e-mail: HOME _____ WORK _____ NO EMAIL _____

SECTION 2: HEALTH COVERAGE

COVERAGE LEVEL (Check one) Individual 2-Person Family

CONTRIBUTION METHOD (Check one) Pre-tax Post-tax

(If you are eligible, your contributions will automatically be made on a pre-tax basis unless you specifically elect post-tax.)

- OPTION (Check one)
- UnitedHealthcare of NE, Inc. — **Choice Plus** (comprehensive coverage)
 - Blue Cross Blue Shield of RI — **HealthMate 100/80** (comprehensive coverage)
 - Blue Cross Blue Shield of RI — **HealthMate 80/60** (catastrophic coverage)
 - No Coverage — *Waive/Drop* (no health insurance Buyout)
 - No Coverage — **Health Insurance Buyout (Please complete below all required information about your alternate health insurance coverage.)**

To receive the Buyout, you MUST provide the following information:

Alternate Insurance Carrier: _____ Alternate Policy #: _____

Alternate Plan Sponsor: _____ Name of Alternate Policy Holder: _____

HEALTH/BUYOUT EFFECTIVE DATE: ___/___/___
MO DY YR

INIT. DATE

Entered by: _____

Verified by: _____

SECTION 3: DENTAL COVERAGE

COVERAGE LEVEL (Check one) Individual 2-Person Family

CONTRIBUTION METHOD (Check one) Pre-tax Post-tax

(If you are eligible, your contributions will automatically be made on a pre-tax basis unless you specifically elect post-tax.)

- OPTION (Check one)
- Delta Dental of RI — **Comprehensive** Drop/Waive Dental Coverage
 - Delta Dental of RI — **Plus (requires 2-year commitment)**

DENTAL EFFECTIVE DATE: ___/___/___
MO DY YR

INIT. DATE

Entered by: _____

Verified by: _____

SECTION 4: VOLUNTARY LIFE INSURANCE

OPTION (Check one)

- Employee Coverage
- No Voluntary Life insurance coverage
- Additional Voluntary coverage
 - equal to 1 times my base salary
 - equal to 2 times my base salary
 - equal to 3 times my base salary
 - equal to 4 times my base salary
 - equal to 5 times my base salary
 - equal to 6 times my base salary
- Dependent Coverage* for Spouse/Partner
 - \$10,000
 - \$20,000
 - \$30,000
 - \$40,000
 - \$50,000
- Dependent Coverage* for Child(ren)
 - _____ Number of children for whom coverage is being requested.

* An employee must be covered for Basic and Voluntary Life Insurance coverage before dependents can be covered.

VOLUNTARY LIFE EFFECTIVE DATES:

– Employee ___/___/___
MO DY YR

– Dependent Spouse/Partner ___/___/___
MO DY YR

– Dependent Child(ren) ___/___/___
MO DY YR

INIT. DATE

Entered by: _____

Verified by: _____

COST OF COVERAGE: All costs related to Voluntary Life Insurance will be paid in full by employees as described in the *Decision Guide*.

STATEMENT OF HEALTH: If any of the following situations applies to you, you must submit a Statement of Health form for approval before your additional voluntary coverage will become effective. Call 401-863-2141 for a Statement of Health form or scroll to "S" at: http://www.brown.edu/Administration/Human_Resources/forms/index.html.

- (Check all that apply)
- I have been hospitalized within the past 90 days;
 - I am eligible for voluntary life insurance through Brown for the first time and my election results in a coverage amount for me greater than \$500,000 and/or for my spouse or same-sex domestic partner greater than \$30,000;
 - I was previously eligible for voluntary life insurance, but am now electing it for the first time; or
 - I currently have and am increasing my level of voluntary life insurance coverage.

SECTION 5: FLEXIBLE SPENDING ACCOUNTS

(PLEASE COMPLETE SECTION 6 AS WELL, IF APPLICABLE)

TERM CODE: _____

MEDICAL REIMBURSEMENT PLAN (MRP) (Check one)

I do want to participate in the MRP. (To elect the MRP, you MUST fill in all information below.)

- Total Annual Contribution (minimum \$240; maximum \$5,000 per calendar year): \$ _____

I do not want to participate in the MRP

DEPENDENT CARE ASSISTANCE PLAN (DCAP) (Check one)

I do want to participate in the DCAP. (To elect the DCAP, you MUST fill in all information below.)

- Total Annual Contribution (minimum \$240; maximum \$5,000 per calendar year): \$ _____ *

I do not want to participate in the DCAP

* If over \$2,500, I certify that I do not file my Federal Tax Return under Married Separate status.

MRP
EFFECTIVE DATE: _____/_____/_____
MO DY YR

DCAP
EFFECTIVE DATE: _____/_____/_____
INIT. DATE MO DY YR

Entered by: _____

Verified by: _____

SECTION 6: DEPENDENT ENROLLMENT INFORMATION

(Check all that apply to each dependent)

By electing coverage for my dependents, I understand that their eligibility is subject to verification and/or an audit conducted by the Benefits Office or the benefit plan vendor at any time during the period of coverage. Dependents must meet the eligibility requirements specified by the University and the applicable laws (see the Benefits Enrollment Decision Guide).

Name	Social Security # (Required)	Sex	Relationship to You	Date of Birth	HEALTH	DENTAL	VOL LIFE	STUDENT*
_____ LAST FIRST MI	_____	_____	_____	_____/_____/_____ MO/DY/YR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ LAST FIRST MI	_____	_____	_____	_____/_____/_____ MO/DY/YR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ LAST FIRST MI	_____	_____	_____	_____/_____/_____ MO/DY/YR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ LAST FIRST MI	_____	_____	_____	_____/_____/_____ MO/DY/YR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ LAST FIRST MI	_____	_____	_____	_____/_____/_____ MO/DY/YR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Certification required if student and age 19 to 25.

Attach separate sheet for additional information.

SECTION 7: BENEFICIARY DESIGNATION

Please list under "Primary Beneficiaries" your first choice of a person or people you wish to receive benefits from your Brown University basic life insurance and, if you purchase it, your employee voluntary life insurance. Under "Contingent Beneficiaries," please list your choice of a person or people to receive your life insurance benefits if none of your primary beneficiaries is alive on the date of your death. In either case, if you list more than one beneficiary, you must tell us the percentage of benefit you want each to receive or the entire benefit will be divided equally among all beneficiaries.

Please specify other distribution arrangements in a separate letter.

PRIMARY BENEFICIARIES

Name	Relationship to You	Date of Birth	Social Security #	Percent of Share
_____ LAST FIRST MI	_____	_____/_____/_____ MO DY YR	_____	_____
_____ LAST FIRST MI	_____	_____/_____/_____ MO DY YR	_____	_____
_____ LAST FIRST MI	_____	_____/_____/_____ MO DY YR	_____	_____
_____ LAST FIRST MI	_____	_____/_____/_____ MO DY YR	_____	_____

CONTINGENT BENEFICIARIES

Name	Relationship to You	Date of Birth	Social Security #	Percent of Share
_____ LAST FIRST MI	_____	_____/_____/_____ MO DY YR	_____	_____
_____ LAST FIRST MI	_____	_____/_____/_____ MO DY YR	_____	_____

Attach separate sheet for additional information.

SECTION 8: EMPLOYEE APPROVAL AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have read the Brown University Year 2010 Benefits Enrollment Decision Guide and understand the benefit choices I have made. I agree to abide by the terms and regulations described in the participant agreements for the plans in which I have enrolled. Further, I authorize that the appropriate administrator(s) for the plans that I have elected may have access to necessary records for me and my dependents. I understand that there may be certain coverage limitations or features based on carrier contract and/or Brown policy. Brown University is not bound to provide coverage in excess of what is considered by the plan administrator to be reasonable and/or prudent for the plan. I authorize my selections and any payroll deductions required for those selections. I also understand that the above elections are effective for calendar year 2010 and may not be changed during the year unless I have a qualifying event (and supply the necessary documentation in the required time period). If electing the Buyout, I certify that the alternate health plan that covers me and my eligible dependents is a group medical plan that is primary to Medicare. I have also read Brown University's Notice of Privacy Practices on page 4 of the yellow copy of this form. It describes how my health information may be used or disclosed. I am aware that the Notice may change at any time and that I may obtain a hard copy or a revised Notice by calling 401-863-2141. Finally, I affirm that the above information I have provided is true and accurate.

Signature _____ Date _____

Notice of Privacy Practices for Employees Participating in the Brown University Health Care Benefit Plans

In Effect Since January 1, 2008

This notice covers the following Brown University Health Care Benefits Plans:

Brown University Medical Reimbursement Plan administered by Benefit Strategies LLC Plan 507

Brown University Dental Plan administered by Delta Dental of Rhode Island Plan 503

Brown University Health Insurance Plans administered by:

- Blue Cross Blue Shield of Rhode Island Plan 504
- UnitedHealthcare of New England Plan 506

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this information carefully.

The Brown University Health Benefit Plans listed above (hereinafter referred to collectively as "the PLAN") are committed to protecting the privacy of health information maintained both by the PLAN itself and by outside vendors who perform services for the PLAN, such as the PLAN's third-party administrator. The PLAN is required by law to protect the privacy of certain health information that may reveal your identity, and to provide you with a copy of this notice which describes the PLAN's privacy practices. If you have any questions about this notice or would like further information, please contact the Brown University Benefit Office at (401) 863-2141.

Use and Disclosure of Your PLAN Information

The PLAN is required by law to maintain the privacy of your Protected Health Information and is committed to doing so. Protected Health Information includes information that may identify who you are such as unique numbers and geographic information. It also includes information about payment for your health care such as your enrollment in the PLAN, information about your health condition such as diseases you may have, and information about health services you have or may receive, such as an operation.

The PLAN will generally obtain your written authorization before using your health information or sharing it with others outside the PLAN. However, the PLAN is permitted to use and disclose your health information for the following purposes **without your written authorization**:

• Payment

The PLAN may use and disclose your health information to administer payments for treatment covered under the PLAN. For example, your health information may be shared with your health care provider in connection with paying for your health care. This information may also be shared with the PLAN's third-party administrator in connection with paying for your health care treatment. However, to the extent the PLAN relies upon the services of a third-party administrator, the PLAN will enter into a written confidentiality agreement with that administrator protecting the privacy of your health information.

• Health Care Operations

The PLAN may use and disclose your health information for general administration of the PLAN and to conduct normal business operations. Examples of business operations include enrolling you in a health PLAN, underwriting, premium rating and other activities related to PLAN coverage; conducting quality assessment and improvement activities; conducting or arranging for legal and audit services, and other management functions including claims administration.

• Emergencies

In an emergency, the PLAN may disclose your health information but only if such disclosure is necessary to protect the health and safety of you or other individuals.

• Public Health and Law Enforcement:

To the extent required by law, the PLAN may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

• Employer

The PLAN may disclose certain of your health information to the Employer. Upon a request from the Employer, the PLAN may disclose health information about you to enable the Employer to obtain premium bids from health plans that might provide health insurance coverage under the PLAN, or to modify, amend, or terminate the PLAN; however, the information the PLAN discloses will not include any information that identifies you other than your zip code. The PLAN may also disclose to the Employer information on whether you are participating in, enrolled in, or are disenrolled from the PLAN. The PLAN may disclose health information about you, including information that identifies you, only if it is necessary for the Employer to administer the PLAN. For example, the Employer may need such information to process health benefits claims, to audit or monitor the business operations of the PLAN, or to ensure that the PLAN is operating effectively and efficiently. The PLAN, however, will restrict the Employer's uses of your information to purposes related to PLAN administration. The PLAN prohibits the Employer from using your information for uses unrelated to PLAN administration. Under no circumstances will the PLAN disclose your health information to the Employer for the purpose of employment-related actions or decisions (e.g. for employment termination) or for the purpose of administering any other PLAN that the Employer may offer. Once received, the Employer may only disclose your health information to third parties, such as to consultants or advisors, if the Employer has first obtained a confidentiality agreement from the person or organization receiving your health information.

• Workers Compensation

The PLAN may disclose your health information to the extent required by laws relating to workers compensation and other similar programs.

• Information that Does Not Identify You

The PLAN may use or disclose your health information if the PLAN has removed all information that might reveal who you are, or for limited purposes if the PLAN has removed most information revealing who you are and obtained a confidentiality agreement from the person or organization receiving your health information.

• As Required by Law

The PLAN may use or disclose your health information if the PLAN is required by law to do so. The PLAN will notify you of these uses and disclosures if notice is required by law.

The PLAN will not use or disclose your health information for any other purpose without first securing your written authorization. If you provide the PLAN with such authorization, you may revoke it at any time, except to the extent that the PLAN has already relied on it. To revoke such authorization, please contact the Brown University Benefits Office at (401) 863-2141. Special privacy protections may apply to information regarding substance abuse, mental health, and HIV.

Your Rights

The Health Insurance Portability and Accountability Act provides you the following rights with respect to access and control of your health information. Please note,

to the extent that the PLAN has provided any of your information to the third-party administrator of the PLAN, you must make your request directly to that third-party administrator whose contact information appears below. Under the law, you have:

- The right to request restrictions as to how your health information is used or shared with others. The PLAN will try to accommodate all reasonable requests.
- The right to receive health information from the PLAN in a form or manner that more fully safeguards the confidentiality of the information; for example, you may request that such information be sent to your home address or another mailing address of your choice.
- The right to inspect and copy your health information.
- The right to correct your health information.
- The right to receive a list of non-routine disclosures of your health information.
- The right to receive a paper copy of this notice at any time by contacting the Brown University Benefits Office at (401) 863-2141 if you received this notice electronically.

Personal Representative

You have the right to name a personal representative who may act on your behalf to control privacy information. If you wish to take advantage of this right, please contact the Brown University Benefits Office at (401) 863-2141.

Policy Modifications

The PLAN may change its privacy practices from time to time. However, if that happens, the PLAN will revise this notice and will notify you either by e-mail or campus mail of the changes. If you do not wish to receive notifications by email and want a paper copy of the notice please contact the Brown University Benefits Office at (401) 863-2141.

Further Information

If you have questions and would like additional information, you may contact the Brown University Benefits Office at (401) 863-2141. For information or questions specifically regarding claims submitted to your PLAN's third-party-claims administrator, please see the phone numbers listed below.

Complaints

Federal law requires the PLAN to maintain the privacy of your PLAN records as set forth in this notice. If you believe your privacy rights have been violated, you can file a complaint with the Brown University Benefits Office at (401) 863-2141.

You may also file complaints with the Secretary of the Department of Health and Human Services or with the third-party administrator for your particular plan using the phone numbers listed below. No one will retaliate or take action against you for filing a complaint.

HIPAA Contacts:

Blue Cross Blue Shield of Rhode Island	1-401-459-5000
UnitedHealthcare	1-866-633-2446
Delta Dental of Rhode Island	1-800-843-3582
Benefit Strategies LLC	1-800-371-7542