Duke HUMAN RESOURCES

2022 Open Enrollment

Medical/Dental/Vision Enrollment Form

Employee Last Name	First Name	MI	Birthdate	Sex	Duke Unique ID	Hire Date

Home Address			Phone(s)	Payroll Cycle
			Home:	☐ Biweekly
City:	State:	Zip:	Office:	☐ Monthly
New home address? ☐ Yes ☐ No	**Tobacco status** - have you used tobacco in any form more than five times in the months (excludes nicotine gum and patches)? ☐ Yes ☐ No			

__ Duke Select HMO _Duke Basic HMO _Duke Options PPO _Blue Care HMO _No Coverage

Medical Plan Effective Date: JANUARY 1, 2022

Medical Coverage Level: EE Only EE + Spouse EE + Child EE + Children EE + Family

My Dental Plan Election is: (select one) *

__ Dental PPO _Plan A _Plan B _No Coverage

Dental Plan Effective Date: JANUARY 1, 2022

Dental Coverage Level: ☐ EE Only ☐ EE + Spouse ☐ EE + Child ☐ EE + Family

*If you or a dependent are not currently enrolled for **2021** dental coverage through Duke and enroll for **2022**, you and/or the dependent will be considered a "late entrant. As a "late entrant" your benefits for the first 12 months will be limited to preventive services: two preventive routine care exams (not including x-rays), two prophylaxis (routine) cleanings, and for children under age 19, one fluoride application. No other procedures would be covered during the first 12 months.

My Vision Plan Election is: (select one)

Vision Plan | No Coverage

Vision Plan Effective Date: JANUARY 1, 2022

Vision Coverage Level: EE Only EE + Spouse EE + Child EE + Children EE + Family

I wish to cover the following dependents under my medical, dental, and/or vision plan as indicated below:

Relation	Medical	Dental*	Vision	Last Name	First Name	MI	Sex	Birthdate	Social Security Number
Spouse	Y/N	Y/N	Y/N						
Child	Y/N	Y/N	Y/N						
Child	Y/N	Y/N	Y/N						
Child	Y/N	Y/N	Y/N						

Definition of Dependent(s): Child(ren): Your natural children, stepchildren, adopted children, children of your registered same sex spousal equivalent, foster children or children for whom you are a legal guardian, up to their 26th birthday, or who are mentally or physically disabled and incapable of self-support after 26, as long as their disability began before they turned 26, and they were covered under a Duke medical plan when they turned age 26.

Spouse: Your legal spouse. Or same-sex spousal equivalent registered with Duke HR prior to January 1, 2016.

Ineligible: Under no circumstances may an employee enroll grandchildren, siblings, or other family members, or children of whom you have legal custody but not guardianship.

Do any of these persons listed above (including yourself) have additional medical or dental coverage? ☐ **Yes** ☐ **No**

Medical	Dental	Individual	Family	Name of person with other coverage	Policy#	Effective Date
☐	☐	☐	☐			
Name and Address of Insurer:						

Authorization for Release of Information To: All hospital and other health care providers, insurers, benefit plan sponsors and administrators, and the prescription drug program. On behalf of myself and each of my dependents covered under the health or dental plan for which I have enrolled (the "Plan"), I authorize you to furnish the insurer, the third party administrator of the Plan ("TPA"), its agents and affiliates, with copies of any information and records related to enrollment and any claim made for benefits under the Plan for myself or my covered dependents. I understand that any release or disclosure of information and records concerning the medical condition or treatment of myself, or any covered dependent, shall only be made as provided under the terms of the administrative services agreement between Duke University and TPA–i.e., in good faith to the proper parties and as necessary for the proper evaluation and administration of the Plan or as otherwise required by law, regulation, or judicial/administrative order. Where practicable, any such disclosure of my, or my covered dependent(s)' medical condition or treatment shall be made without disclosure of our identity. This authorization shall be valid for the duration of my enrollment in the Plan.

Authorization for Salary Reduction: I have read the information and understand the benefit choices available to me. I hereby authorize Duke to reduce my salary by the amount of the premium for the plans selected including the $50 monthly tobacco surcharge based upon my disclosed tobacco use status. I understand that the choices I have made on this form cannot be changed until the next Open Enrollment period unless I notify the Human Resource Information Center (919-684-5600) within 30 days of having a qualifying event, as defined by law, or special enrollment period.

Certification: I certify that the information I have provided on this form is true and accurate. Any material misrepresentation or deliberate omission of fact may be justification for disciplinary action or termination from Duke University/Duke University Health System. I also understand that if any benefit payments are paid/received for persons who do not meet the definition criteria for a dependent, I will be responsible for reimbursing premiums paid by Duke and all claims payments.

⊙ _____ _____

Employee Signature Date Signed

Mail to: Benefits Box 90502, 705 Broad Street, Durham, NC 27708 or fax (919) 681-8774

Please retain a copy for your records.