HUMAN RESOURCES MANAGEMENT

BENEFITS DROP/ADD FORM

I, _____ SS# _____

DO HEREBY AUTHORIZE ALBANY STATE UNIVERSITY TO DROP/ADD THE FOLLOWING BENEFITS:

INDIVIDUAL HEALTH INSURANCE COVERAGE	☐ DROP	☐ ADD
FAMILY HEALTH INSURANCE COVERAGE	☐ DROP	☑ ADD
INDIVIDUAL DENTAL INSURANCE COVERAGE	☐ DROP	☐ ADD
SUPPLEMENTAL LIFE (1), (2), (3)	☐ DROP	☐ ADD
FAMILY LIFE COVERAGE	☐ DROP	☐ ADD
SECTION 125 (FOR SUPPLEMENTAL LIFE)	☐ DROP	☐ ADD
FLEXIBLE SPENDING ACCOUNT-MEDICAL	☐ DROP	☐ ADD
FLEXIBLE SPENDING ACCOUNT-DEPENDENT CARE	☐ DROP	☐ ADD
RETIREE WITH MEDICARE	☐ DROP	☐ ADD
RETIREE WITH DEPENDENTS WITH MEDICARE	☐ DROP	☐ ADD

REASONS FOR CHANGES MADE

☐ RETIREMENT ☐ TERMINATION ☐ VOLUNTARY ☐ OPEN ENROLLMENT

ADDITIONS OR DELETIONS OF COVERAGE MAY ONLY BE MADE DURING OPEN ENROLLMENT OR WITHIN 31 DAYS OF APPROVED CHANGE OF STATUS DUE TO :

☐ A. ACQUIRING DEPENDENTS
☐ B. LOSS OF DEPENDENTS BY:

- ☐ 1. DEATH
- ☐ 2. DIVORCE
- ☐ 3. MARRIAGE
- ☐ 4. MARRIAGE OF A DEPENDENT
- ☐ 5. ATTAINMENT OF MAXIMUM AGE COVERED
- ☐ 6. SPOUSE LOSS OF COVERAGE UNDER THIS PLAN BECAUSE OF CHANGE OF EMPLOYMENT STATUS

I HAVE BEEN ADVISED OF MY RIGHTS TO CONTINUE MY HEALTH/DENTAL INSURANCE COVERAGE UNDER COBRA.

1, ☐ DO ☐ DO NOT, WISH TO CONTINUE MY HEALTH INSURANCE UNDER COBRA.

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE