BENEFITS

NAU NORTHERN ARIZONA UNIVERSITY

Human Resources

2020 Benefit Change Form

As a result of recent change in regulations employees will be allowed to make mid-year changes to their benefit elections through December 31, 2020. Please complete this form and return it to Human Resources. All changes will be effective the first day of the pay period following the submission of a completed change form. Requested changes to your benefits may be delayed if the submitted form is incomplete. You can find information about on your voluntary benefits offerings at https://in.nau.edu/human-resources/benefits-offered/.

Employee Information

Employee ID_____ Employee Name _____

Medical

□ Cancel\waive current coverage – I attest that I have other medical coverage, or will I will immediately enroll in medical coverage.
□ Continue medical election □ Change coverage – indicate your new election below

Plan	Network	Employee Only	Employee and Spouse	Employee and Child	Family
NAU Medical Plans					
□ PPO	BCBSAZ	□ $44.32	□ $120.62	□ $86.16	□ $179.01
□ HDHP\HSA	BCBSAZ	□ $5.54	□ $21.23	□ $16.66	□ $47.12
State of Arizona Medical Plans					
□ PPO	□ Aetna □ BCBS AZ □ UHC	□ $53.34	□ $112.43	□ $75.30	□ $131.25
□ EPO	□ Aetna □ BCBS AZ □ CIGNA □ UHC	□ $20.92	□ $62.23	□ $52.82	□ $115.57
□ HDHP\HSA	□ Aetna	□ $10.15	□ $30.46	□ $25.89	□ $ 56.35

Dental

□ Cancel\waive current coverage – I attest that I have other dental coverage, or will I will immediately enroll in dental coverage.
□ Continue medical election □ Change coverage – indicate your new election below

Plan	Network	Employee Only	Employee and Spouse	Employee and Child	Family
□ PPO	Delta Dental Premier	□ $14.30	□ $30.33	□ $23.34	□ $48.26
□ DHMO	CIGNA HMO	□ $1.64	□ $3.29	□ $3.08	□ $5.46

Vision

□ Cancel\waive current coverage – I attest that I have other vision coverage, or will I will immediately enroll in vision coverage.
□ Continue current election □ Change coverage – indicated\ your new election below

Plan	Network	Employee Only	Employee and Spouse	Employee and Child	Family
□ PPO	Avesis Advantage	□ $1.84	□ $5.97	□ $5.89	□ $7.43

Covered Dependents

Plans Enrolled	Dependent Name	SSN *(required)*	Date of Birth	Sex	Relationship
□ ***Medical*** □ ***Dental*** □ **Vision**	_____	_____	_____	□ ***Male*** □ ***Female***	□ ***Spouse*** □***Child***
□ ***Medical*** □ ***Dental*** □ **Vision**	_____	_____	_____	□ ***Male*** □ ***Female***	□ ***Spouse*** □***Child***
□ ***Medical*** □ ***Dental*** □ **Vision**	_____	_____	_____	□ ***Male*** □ ***Female***	□ ***Spouse*** □***Child***
□ ***Medical*** □ ***Dental*** □ **Vision**	_____	_____	_____	□ ***Male*** □ ***Female***	□ ***Spouse*** □***Child***

Individual Supplemental Life

NAU Supplemental Life - The Hartford (formally Aetna):

□ Continue current election □ Cancel\waive current coverage □ Change coverage – New Amount _____

□ 1 times salary □ 2 times salary □ 3 times salary

State of AZ Supplemental Life – Securian $5,000 to $500,000 – Supplemental life insurance may only be increased in increments of $20,000 once per year.

□ Continue current election □ Cancel\waive current coverage □ Change coverage – New Amount _____

Dependent Supplemental Life

NAU Supplemental Life–The Hartford (formally Aetna)

□ Continue current election □ Cancel\waive current coverage □ Change coverage – New Amount _____

State of AZ Supplemental Life – Securian

□ Continue current election □ Cancel\waive current coverage □ Change coverage – New Amount _____

Short Term Disability (STD)

NAU STD - Unum

□ Continue current election □ Cancel\waive current coverage □ Change coverage – indicate your new election below:

□ Option A -$750 max weekly benefit □ Option B -$1,500 max weekly benefit □ Option C -$2,000 max weekly benefit

State of AZ STD – MetLife

□ Continue current election □ Cancel\waive current coverage □ Elect coverage

Flexible Spending Accounts (FSA)

Health Care

□ Continue current election □ Cancel\waive current coverage □ Change coverage – New Amount _____

Dependent Care

□ Continue current election □ Cancel\waive current coverage □ Change coverage – New Amount _____

Note: You unable to decrease your annual contribution amount under the about you have contributed or used in the calendar year.

Employee Authorization and Signature

I hereby certify, under penalty of perjury, that the information I have provided in this application for employee benefits, including address and spouse and/or dependent information is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. I authorize my employer to reduce my salary by applicable pre-tax dollars or reduce my paycheck by the applicable after-tax dollars for the insurance programs which I have elected. In addition, I have read and understand the declarations. I hereby acknowledge that I have received the Summary of Benefits and Coverage Documents in accordance with The Affordable Care Act ACT).

Employee Signature: _____ Date: _____

Return the completed form to Human Resources: Email NAUHRBenefits@nau.edu or Fax 928-523-2220