ASSOCIATED UNIVERSITIES, INC.
Medical, Dental & Vision Enrollment Form

Personal Information

Name: _____ Employee #: _____ Eff Date: _____

Street: _____ City: _____ State: _____ Zip: _____

New Employee ☐ Single ☐ DOB: _____ Phone: _____

Coverage Change ☐ Married ☐ SSN: _____ Gender: ☐ F ☐ M FLSA: ☐ E ☐ NE

Benefit Elections

Medical		*Dental*	*Vision*
☐ Accepted ☐ HSA ☐ HRA	☐ Refused	☐ Basic ☐ Comprehensive ☐ Refused	☐ Accepted ☐ Refused

Covered Dependents

Full Name & Coverage Election	*DOB*	*Relationship*	*Gender*	*SSN*
Med ☐ *Den* ☐ *Vis* ☐		Spouse	*M* ☐ *F* ☐	
Med ☐ *Den* ☐ *Vis* ☐		Child	*M* ☐ *F* ☐	
Med ☐ *Den* ☐ *Vis* ☐		Child	*M* ☐ *F* ☐	
Med ☐ *Den* ☐ *Vis* ☐		Child	*M* ☐ *F* ☐	
Med ☐ *Den* ☐ *Vis* ☐		Child	*M* ☐ *F* ☐	
Med ☐ *Den* ☐ *Vis* ☐		Child	*M* ☐ *F* ☐	

Employee Authorization

I authorize Associated Universities, Inc. to reduce my taxable salary in accordance with IRC Section 125 for the required employee premiums for the Group Medical, Dental, and/or Vision coverages I have elected. This agreement will remain in force until I give AUI 30 days' written notice of termination due to qualifying event or open enrollment elections.

_____ _____

Employee Signature Date

HR USE ONLY

_____ Conexis _____ HRIS _____ Medical _____ Dental _____ Vision

Qualifying Event Type: _____ Date of Event: _____