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 ☐ Non-Binary

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

________ WageWorks ________ HRIS ________ Medical ________ Dental ________ Vision

Qualifying Event Type: ______________________ Date of Event: ______________