



**ASSOCIATED UNIVERSITIES, INC.
NATIONAL RADIO ASTRONOMY OBSERVATORY
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	Refused	Basic	Accepted	Refused
HSA		Comprehensive		
HRA		Refused		

Covered Dependents

<i>Full Name & Coverage Election</i>			<i>DOB</i>	<i>Relationship</i>	<i>Gender</i>	<i>SSN</i>
<i>Med</i>	<i>Den</i>	<i>Vis</i>	_____	_____	<i>M</i> <i>F</i>	_____
_____	_____	_____	_____	_____	<i>M</i> <i>F</i>	_____
<i>Med</i>	<i>Den</i>	<i>Vis</i>	_____	_____	<i>M</i> <i>F</i>	_____
_____	_____	_____	_____	_____	<i>M</i> <i>F</i>	_____
<i>Med</i>	<i>Den</i>	<i>Vis</i>	_____	_____	<i>M</i> <i>F</i>	_____
_____	_____	_____	_____	_____	<i>M</i> <i>F</i>	_____
<i>Med</i>	<i>Den</i>	<i>Vis</i>	_____	_____	<i>M</i> <i>F</i>	_____
_____	_____	_____	_____	_____	<i>M</i> <i>F</i>	_____
<i>Med</i>	<i>Den</i>	<i>Vis</i>	_____	_____	<i>M</i> <i>F</i>	_____
_____	_____	_____	_____	_____	<i>M</i> <i>F</i>	_____

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: _____