THE NEW SCHOOL
HEALTH CARE PLAN ENROLLMENT/CHANGE FORM (FULL–TIME FACULTY AND STAFF)

Employee University ID# N _____

A. Employee Information *Please Print Clearly*

Social Security Number	Last Name, First Name, MI	Marital Status ☐ Single ☐ Married	Birthdate (MM/DD/YY) / /	Home Telephone
Gender ☐ Female ☐ Male	Home Address*	City	State	Zip Code

*Your payroll address on file with the University will be provided to UnitedHealthcare and will be used for all correspondence you will receive from UnitedHealthcare.

B. Type of Activity *Please Print Clearly*

Instructions: You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

Enrollment Type ☐ New

☐ Add Spouse/Domestic Partner ☐ Add Dependent Child ☐ Remove Spouse/Domestic Partner ☐ Remove Dependent Child

☐ Cancel Coverage ☐ Name Change ☐ Plan Change (Open Enrollment Only)

C. Plan Options

☐ Choice Plus 500 ☐ Choice Plus 1000 ☐ Choice EPO ☐ High Deductible Health Plan with Health Savings Account
(You must complete a separate enrollment form before contributions to a Health Savings Account may begin.)

D. Dependents Enrolled *Please Print Clearly*

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last)	Relationship to Employee**	Gender (F) (M)	Birthdate MM / DD / YY	Social Security Number If dependent has no SSN write none
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				/ /	
				/ /	
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** A copy of your marriage certificate is required to enroll a spouse. If you are enrolling a domestic partner you must complete a Statement of Domestic Partnership and provide supporting documentation.
A copy of your child's birth certificate is required if enrolling a child.

E. Employee Signature

I certify that all information supplied in this form is true and completed to the best of my knowledge and/or belief. I authorize pre-tax deductions from my earning for any contributions required for coverage and I agree to make any necessary payments as required for coverage. The Plan documents will determine the rights and responsibilities of the member(s) and will govern in the event they conflict with any benefits comparison, summary, or other description of the plan.

Employee Signature–Required

Date / /

New School E-Mail Address

HR SECTION: Effective Date _____ /_____ /_____