

If married, does (did) your spouse work for the University of Dayton in a benefit eligible position? *Yes* *No*

Spouse's Status: *Faculty* *Staff* *Grad Assistant* *Spouse's Name:* _____

Medicare Part A Effective Date: _____

Part B Effective Date: _____

Medicare ID # _____

Terms, conditions, and authorizations:

I hereby authorize the University of Dayton to have Business Plans, Inc. invoice me for any applicable premiums for the elections made within this application. I understand that my elections made within this application must be provided to the Office of Human Resources within 30 days of a qualified life event. I authorize the University of Dayton to communicate to its vendors any information necessary to complete the enrollment / disenrollment process. I understand that the completion of this document is not a guarantee of coverage and that the Office of Human Resources and its vendors will make the determination on the acceptance of this request. I know that I am responsible for notifying Human Resources of any life event that might impact my benefit elections and changes needed.

This application hereby replaces any previous elections made and are fixed until:

1. My employment / benefit eligible status changes
2. I have a qualified life event and notify HR within 30 days
3. I fail to make premium payments for my coverage
- 4.

I certify that this application is complete with accurate information and acknowledge that providing false information can lead to the denial of benefits.

Signature: _____ **Date:** _____