USG Family Status Change Form – Marriage Event

Revision 01 | Date 07/09/2015

Instructions

Submit Form for Processing:

1. Complete, print, and sign the form.
2. Send the form along with the required documentation to the USG Shared Services Center (SSC) using one of the following methods:
   - Fax to (478) 240-6414
   - Hand deliver to your Institution's HR/Benefits department

   Important: To ensure the protection of your personal information, **do not email** this form.

To View Your Current Benefit Elections:

1. Log into the **ADP System** at https://portal.adp.com
2. Click the **Benefits** tab, then click the **My Benefits** link
3. Click **Continue** on your landing page
4. On the Benefits Main Menu, click **2015 Benefit Summary**

For more information about USG Benefits:

Visit the USG Benefits Website at http://www.usg.edu/hr/benefits/coverage_options

Need Assistance?

If you have questions or need assistance, please contact our Shared Services Center Customer Support team or your institution's HR/Benefits department.

The SSC's normal business hours are Monday through Friday 8:00 A.M. – 5:00 P.M. except holidays. You can call us toll free at (855) 214-2644 or email us at helpdesk@ssc.usg.edu.

Employee Personal Information

Last Name		**First Name**		**MI**		**ADP Emp ID**	
Institution		**Phone**		**Email**			

Effective Date for Benefits *(select one)* ☐ **6/26/2015** * ☐ **7/1/2015**

* *Premiums must be paid for the entire month if coverage is provided for any portion of the month*

Employee Enrollment Changes *(Any elections left **blank** will retain your current enrollment)*

Life Insurance *(Enroll, increase, decrease, or drop these coverages)*

Supplemental Life with AD&D *(x salary)* ☐ **1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** ☐ **6x** ☐ **7x** ☐ **8x** ☐ **Waive**

Notes:

- *Any increase will **require** Evidence of Insurability (EOI). Minnesota Life will contact you after enrollment*
- *If this is a **new** benefit for you, you are **required** to complete the beneficiary included.*

Spouse Life *(increments of $10,000 up to $500,000)*	**$**	*Amounts above $50,000 will **require** Evidence of Insurability (EOI). Minnesota Life will contact your spouse after enrollment.*	☐ **Waive**

Child Life ☐ **$5,000** ☐ **$10,000** ☐ **$15,000** ☐ **Waive**

Voluntary AD&D *(increments of $10,000 up to $500,000)* **$** ☐ **Employee Only** ☐ **Family** ☐ **Waive**

Note: *If this is a **new** benefit for you, you are **required** to complete the beneficiary included.*

Spending Accounts – Annual Amount (*What you have contributed YTD will be subtracted from the amount below and divided over the remaining pay periods)*

Flexible Spending Account – Healthcare (FSA)	**$**	*Enroll or increase contribution only (annual max. $2,550)*
Flexible Spending Account – Dependent Care (FSA)	**$**	*Enroll or increase contribution only (annual max. $5,000)*
Flexible Spending Account – Limited Purpose (FSA)	**$**	• *Enroll or increase contribution only (annual max. $2,550)* • ***Requires** enrollment in the Consumer Choice HSA Medical Plan*

Spending Accounts *(continued)*

Health Savings Account – (HSA)	**$**	• *Enroll, increase, decrease, or drop (Individual max. $3,350; family $6,650; 55 and older catch-up $1,000)* • ***Requires** enrollment in the Consumer Choice HSA Medical Plan*	☐ **Waive**
GA State Only – Parking Spending Account	**$**	*Increase or decrease contribution only*	
GA State Only – Transit Spending Account	**$**	*Increase or decrease contribution only*	

Add Dependents to current Medical, Dental, and/or Vision coverage *(For each of your dependents, please provide the information in the table below)*

Notes:

- *Documentation required:*
  - *Spouse – official marriage certificate*
  - *Child(ren) – birth certificate*
  - *StepChild(ren) – birth certificate and official marriage certificate*
- *If enrolled in the BlueChoice HMO plan, provide the Primary Care Physician # (PCP)*
- *Tobacco Status - Provide Y/N for all dependents age 18 or older covered by Medical ($75 monthly charge for each tobacco user)*

Last Name	First Name	MI	DOB	SSN	Gender	Relationship (spouse or child)	Medical (Y/N)	Dental (Y/N)	Vision (Y/N)	PCP # (See Notes)	Tobacco Status (Y/N)

Employee Verification

I hereby enroll in the above plan(s) presently contracted for by my employer for which I am or may become eligible. I understand that only those dependents listed on this form who meet the definition of "Dependent" will be covered by the benefits I have elected (refer to the plan summary plan description for the definition of a "Dependent"). With these elections, I understand my employer will reduce my earnings of amounts sufficient to cover my contributions toward the premium under the said group contract(s).

I authorize my selected health plan to obtain, from providers of services and hospitals, the medical records relating to me and my covered dependents which are necessary to the administration of my contract.

I have read and agree to the terms outlined in the summary plan description. I verify all information is true, correct and complete.

Signature of Employee **Date**

Beneficiary Designation

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Employer		Policy number	
University System of Georgia - Board of Regents		**34277 & 34278**	
Insured's name (last, first, middle initial)	Institution name	Last four digits of Social Security number	
Street address	City	State	Zip code
Insured's date of birth	Policyowner (if different than the insured)	Policyowner's telephone number	

This designation applies to (if this section is left blank, your designation will apply to all coverages):

☐ All coverages ☐ Basic Life and AD&D ☐ Supplemental Life and AD&D ☐ Voluntary AD&D

If you are designating a separate beneficiary for each coverage type, use a separate form for each coverage.

INSTRUCTIONS:

1. Print or type in the space below, the full name, address, date of birth, phone number, relationship to the insured, and share % of each beneficiary to be named.
2. **Sign and date the completed form.**
3. Return to your institution's HR/Benefits office.

CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive death proceeds. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children" , without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by Minnesota Life, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name your primary and contingent beneficiaries. To receive death proceeds, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries. In the event of simultaneous death of the insured and a beneficiary, the death proceeds will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the proceeds

Beneficiary Full Name & Address	Date of birth	Phone number	Relationship	Share % **(for primary beneficiaries must total 100%)**

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name & Address	Date of birth	Phone number	Relationship	Share % **(for contingent beneficiaries must total 100%)**

Total = 100%

SIGNATURE REQUIRED

Policyowner's signature	Date
X	