Fashion Institute of Technology

HEALTH CARE ENROLLMENT/CHANGE FORM
Part-Time Employees

1: EMPLOYEE INFORMATION – PLEASE COMPLETE THE ENTIRE SECTION

Name (Last, First, Middle):_____ FIT ID#: @_____

Street Address:_____

City:_____ State:_____ Zip Code: _____

Date of Birth:_____ Gender: _____ Telephone Number: _____

2: HEALTH CARE PLAN – Aetna Open Access Elect Choice EPO Plan

☐ Initial Enrollment

☐ Change: Requested Date of Change: _____

3: ENROLLMENT & CHANGES

List all dependents you are adding, changing, or removing under your coverage. Attach a sheet to list additional dependent(s).

(**A**)dd (**C**)hange (**R**)emove	Last Name, First Name, M.I.	Gender	Relationship to Employee	Birthdate MM DD YYY	Social Security Number

4: EMPLOYEE AUTHORIZATION: I certify that all information that I have supplied is true to the best of my knowledge. Once elections I have made on this form become effective, they will remain in effect unless I make a change due to a qualified change in family status as defined by law or if I make a change during a subsequent annual open enrollment period. If I waive coverage for myself or my dependent(s), by signing this form, I am acknowledging that I or my dependent(s) have other health care coverage outside FIT (or am/are covered under FIT's health care plan by another employee). I understand that I have 31 days from the date of a qualified change in family status to notify a FIT Benefit Representative of the change in order to modify my election as allowable. 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.

Signature_____ Date_____

FOR EMPLOYER USE ONLY:

Hire Date: Effective Date: Waiver Payment: