DEPARTMENT OF HUMAN RESOURCES
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Telephone 860-486-3034
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UCONN
DEPARTMENT OF HUMAN RESOURCES

GRADUATE FELLOW
2024-2025 HEALTH INSURANCE OPEN ENROLLMENT FORM

Complete this form only if you are changing your current medical or dental election or the dependents you cover. Elections or changes made during GA Open Enrollment will be effective September 1st, 2024.

Enrollment Deadline: August 30, 2024

GRADUATE FELLOW NAME _____ EMPLOYEE ID NUMBER _____

CONTACT INFORMATION (E-MAIL ADDRESS OR TELEPHONE) _____

Place an "X" in the box next to your election

COVERAGE ELECTION (coverage period 09/01/24 – 08/31/25)

	Graduate Only	Graduate Plus One	Family
MEDICAL OPTIONS **Complete this section only if you are changing your current medical election**			
Anthem BCBS: CT Partnership Plan	☐	☐	☐
Waiver of Medical Insurance	☐		
DENTAL OPTIONS **Complete this section only if you are changing your current dental election**			
CIGNA Dental: CT Partnership Plan	☐	☐	☐
Waiver of Dental Insurance	☐		

FALL 2024 Fee Bill Rates:

	MED	DENT
Grad Only	$116.65	$55.45
Grad + One	$600.00	$110.80
Family	$759.15	$221.60

SPRING 2025 Fee Bill Rates:

	MED	DENT
Grad Only	$163.31	$77.63
Grad + One	$840.00	$155.12
Family	$1,062.81	$310.24

Graduate Fellows and Postdoctoral Fellows will be billed on their fee bill or directly by the Payroll Office.

DEPENDENTS

ADD DEPENDENTS – Write in the information about the dependents you want enrolled. List only those dependents not currently enrolled. You must provide proof of eligibility (Marriage Certificate, Birth Certificate(s), etc.) when enrolling dependents:

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SEX	SSN	COVERAGE
					MEDICAL ☐ DENTAL ☐
					MEDICAL ☐ DENTAL ☐
					MEDICAL ☐ DENTAL ☐
					MEDICAL ☐ DENTAL ☐

over

DELETE DEPENDENTS – Write in the information about the dependents you want deleted from coverage.

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	COVERAGE TO DELETE
			MEDICAL ☐ DENTAL ☐
			MEDICAL ☐ DENTAL ☐
			MEDICAL ☐ DENTAL ☐

HEALTH ENROLLMENT AUTHORIZATION

I hereby apply for membership in the plan(s). I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services will be available subject to the exclusions, limitation and conditions described by the health plan.

I authorize any physician, hospital, insurer, or other organization or person having records, data or information concerning health history or medical insurance, including those related to HIV/AIDS information or psychiatric, drug or alcohol abuse for me or my family member(s), to furnish such records, data or information as may be requested by the organization providing the benefits under the health plan or its underwriting department or representatives involved in collecting information for use in connection with verification or confirmation of claims for benefits under the health benefit plan. A photocopy of this authorization shall be considered as effective and valid as the original.

I certify that all information on this form is correct to the best of my knowledge and belief, and understand that providing false and/or incomplete information may result in rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s).

I hereby authorize the State Comptroller to make deductions, if applicable, from my payroll check for the medical and/or dental insurance indicated above.

Graduate Fellow Signature: _____ **Date:** _____

Please **SUBMIT** your completed Open Enrollment Form to Benefits@uconn.edu if it does not contain SSN information. If you are adding dependents and your form contains SSN information, please fax your form to 860-486-0378.

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