DEPARTMENT OF HUMAN RESOURCES
9 WALTERS AVENUE, UNIT 5075
STORRS, CT 06269-5075
Telephone 860-486-0400
Facsimile 860-486-0406

UCONN

HEALTH INSURANCE ELECTION FORM FOR ADJUNCT FACULTY

EMPLOYEE NAME (LAST, FIRST)	EMPLOYEE BIRTH DATE	EMPLOYEE ID

EMPLOYEE ADDRESS

BELOW ARE THE MEDICAL AND DENTAL INSURANCE OPTIONS AND THEIR MONTHLY COSTS. YOU MAY CHANGE YOUR ELECTIONS EACH YEAR DURING OPEN ENROLLMENT OR SOONER IF YOU HAVE A QUALIFYING STATUS CHANGE.

FOR NEW ADJUNCT FACULTY OR ADJUNCT FACULTY WHO ARE ENROLLING FOR THE FIRST TIME, COVERAGE WILL BE EFFECTIVE ON THE FIRST DAY OF THE MONTH FOLLOWING THE HIRE DATE.

Check the box next to your election

MONTHLY COSTS (July 1, 2025 – June 30, 2026)

	Employee	Employee + 1	Family
MEDICAL OPTIONS			
Anthem Blue Cross Blue Shield			
Quality First Select Access (Prime POS)	☐ $1,175.47	☐ $2,586.04	☐ $3,173.77
Primary Care Access (POE-Plus)	☐ $1,215.41	☐ $2,673.90	☐ $3,281.61
Standard Access (POE)	☐ $1,235.91	☐ $2,719.00	☐ $3,336.96
Expanded Access (POS)	☐ $1,236.64	☐ $2,720.61	☐ $3,338.93
Out of Area Point-of-Service (POS) *(non-CT residents only)*	☐ $1,669.33	☐ $3,672.53	☐ $4,507.19
Waiver of Medical Insurance	☐ $0.00		
DENTAL OPTIONS			
CIGNA			
Basic	☐ $ 40.26	☐ $ 122.79	☐ $ 122.79
Enhanced	☐ $ 39.43	☐ $ 120.26	☐ $ 120.26
DHMO (Closed to New Enrollments)	☐ $ 23.64	☐ $ 52.01	☐ $ 63.83
Total Care DHMO	☐ $ 29.49	☐ $ 64.88	☐ $ 79.62
Waiver of Dental Insurance	☐ $0.00		

DEPENDENTS

COMPLETE THE SECTION BELOW WITH INFORMATION ABOUT THE ELIGIBLE DEPENDENTS YOU WANT ENROLLED IN YOUR MEDICAL AND/OR DENTAL INSURANCE OPTIONS. YOU MUST PROVIDE PROOF OF ELIGIBILITY WHEN ENROLLING DEPENDENTS.

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

Employee Signature: _____ **Date:** _____

HR USE ONLY	HIRE DATE:	EFFECTIVE DATE (HEALTH):	DATE ENTERED/ INITIALS: