

ENROLLMENT WORKSHEET

This enrollment worksheet is intended to assist new employees with planning insurance and retirement benefits elections. Using this worksheet to prepare for your group counseling session will help you know what questions to ask and what information you'll need to provide to a University benefits counselor. You can use the worksheet to note plan elections and document any questions or comments you may have.

When you attend the group counseling session, a University benefits counselor will take your enrollment worksheet to enter in the system. Once this is complete, you will receive an email from PEBA with a link to MyBenefits. You will need to set up an account to review your enrollment information and approve the transaction. *You will also receive an email from PEBA Retirement explaining how to complete electing your retirement plan online which must be done within 30 days.*

Please note: This four-page worksheet does not take the place of the election process, which you will complete during your benefits counseling session. For security reasons, information contained in the worksheet should not be emailed, faxed or sent via inter-office mail.

Employee Information:

Name: _____

Hire Date: _____

Were you previously a member of the South Carolina Retirement System? Yes No

Do you have prior state or federal service anywhere? Yes No

Health Plans (✓ elected plan):

- Standard State Health Plan
- Savings Plan
- Refuse Health Coverage

Coverage Level (✓ elected level; you may elect to cover eligible children up to age 26):

- Enrollee only
- Enrollee/spouse
- Enrollee/child(ren)
- Family

Tobacco Use: Are you or any of the family members covered on your health plan tobacco users? Yes No

Dental Plans (✓ elected coverage):

Note: To enroll in Dental Plus, Basic Dental is required.

- Basic Dental
- Refuse Basic Dental Coverage
- Dental Plus
- Refuse Dental Plus Coverage

Coverage Level (✓ elected level; you may elect to cover eligible children up to age 26):

- Enrollee only
- Enrollee/spouse
- Enrollee/child(ren)
- Family

Vision Plan (✓ elected coverage):

- State Vision Plan
- Refuse Vision Coverage

Coverage Level (✓ elected level; you may elect to cover eligible children up to age 26):

- Enrollee only
- Enrollee/spouse
- Enrollee/child(ren)
- Family

Basic Life Insurance

Clemson University provides a \$3,000 basic life insurance policy at no cost if you enroll in a state health plan.

Optional Life Insurance - Employee

Enter amount of life insurance coverage selected for yourself (\$10,000 dollar increments up to three times your basic annual salary, not to exceed \$500,000).

Coverage Level: _____ Refuse optional life insurance

Dependent Life Insurance - Spouse

Enter amount of spouse life insurance coverage selected (\$10,000 or \$20,000 without medical evidence, up to half of your optional life insurance coverage level, not to exceed \$100K - with medical evidence).

Coverage Level: _____ Refuse dependent life insurance - spouse

Dependent Life Insurance - Child

✓ Enroll if you elect to cover your eligible children; \$15,000 for each eligible child. Eligible dependents include all dependent children up to age 19 and children ages 19-24 who are full-time students and who are not employed on a full-time basis.

Enroll Refuse dependent life insurance - child

Basic Long-Term Disability Insurance

Clemson University provides a basic, long-term disability policy at no cost if you enroll in a state health plan. This benefit has a 90-day waiting period and pays up to 62.5% of your salary not to exceed \$800 per month.

Supplemental Long-Term Disability Insurance

✓ Enroll to elect supplemental long-term disability coverage, which can replace up to 65% of your monthly salary (with a maximum benefit of \$8,000 per month). This benefit coordinates with the basic long-term disability insurance.

- Enroll - supplemental long-term disability insurance with the 90-day waiting period
- Enroll - supplemental long-term disability insurance with the 180-day waiting period
- Refuse supplemental long-term disability insurance

Required Documentation When Enrolling Family Members

The state requires specific documents for enrollment:

- Legal Spouse: A copy of your marriage license or page one of your most recent federal tax return. Please mark out your financial information.
- Eligible dependent children: The long version of children's birth certificates (with the parents' names).

To obtain a long form birth certificate, see your local S.C. Department of Health and Environmental Control office. You may also request this information by mail. See www.scdhec.gov/VitalRecords/BirthCertificates for instructions. If your child was born outside of South Carolina, go to www.cdc.gov/nchs/w2w.htm for a list of links to vital statistics agencies for other U.S. states and territories.

Dependent Information for State Insurance

Spouse: _____
SSN#: _____ DOB: _____
 Male Female

Coverage for your spouse was noted per your prior selections.

Children to be covered

Name: _____
SS#: _____ DOB: _____
 Male Female

✓ Coverage elected for this child:
 Health
 Dental
 Vision
 Depended Life - Child

Name: _____
SS#: _____ DOB: _____
 Male Female

✓ Coverage elected for this child:
 Health
 Dental
 Vision
 Depended Life - Child

Name: _____
SS#: _____ DOB: _____
 Male Female

✓ Coverage elected for this child:
 Health
 Dental
 Vision
 Depended Life - Child

Beneficiary Information for State Insurance

Basic Life Insurance

Name: _____
Address: _____
SS#: _____ DOB: _____ Relationship: _____
 Primary Beneficiary Contingent Beneficiary %: _____

Name: _____
Address: _____
SS#: _____ DOB: _____ Relationship: _____
 Primary Beneficiary Contingent Beneficiary %: _____

Name: _____
Address: _____
SS#: _____ DOB: _____ Relationship: _____
 Primary Beneficiary Contingent Beneficiary %: _____

Optional Life Insurance

Check if address is included above.

Name: _____
Address: _____
SS#: _____ DOB: _____ Relationship: _____
 Primary Beneficiary Contingent Beneficiary

Name: _____
Address: _____
SS#: _____ DOB: _____ Relationship: _____
 Primary Beneficiary Contingent Beneficiary

Name: _____
Address: _____
SS#: _____ DOB: _____ Relationship: _____
 Primary Beneficiary Contingent Beneficiary

Retirement Plan Election

- SC Retirement System (SCRS) Police Officers Retirement System (PORS)
- State Optional Retirement Program (ORP)
- Vendor
- Mass Mutual
 - MetLife
 - TIAA
 - Valic

Beneficiary Information

State Retirement Funds

Name: _____

SS#: _____ DOB: _____ Relationship: _____

Primary Beneficiary Contingent Beneficiary %: _____

Name: _____

SS#: _____ DOB: _____ Relationship: _____

Primary Beneficiary Contingent Beneficiary %: _____

Name: _____

SS#: _____ DOB: _____ Relationship: _____

Primary Beneficiary Contingent Beneficiary %: _____

Name: _____

SS#: _____ DOB: _____ Relationship: _____

Primary Beneficiary Contingent Beneficiary %: _____

My Estate Address: _____

Trust Trust Name: _____

Address: _____

Date Signed: _____

Incidental Death Benefit

Name: _____

SS#: _____ DOB: _____ Relationship: _____

Primary Beneficiary

Name: _____

SS#: _____ DOB: _____ Relationship: _____

Primary Beneficiary

Name: _____

SS#: _____ DOB: _____ Relationship: _____

Primary Beneficiary

Name: _____

SS#: _____ DOB: _____ Relationship: _____

Primary Beneficiary

My Estate Address: _____

Trust Trust Name: _____

Address: _____

Date Signed: _____