



**NEW YORK MEDICAL COLLEGE**

(Please print or type information)

**GROUP INSURANCE  
MASTER ENROLLMENT FORM**

**EMPLOYEE NAME:** \_\_\_\_\_ **DATE OF HIRE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST NAME FIRST NAME MIDDLE INITIAL

**EMPLOYEE NUMBER OR SOCIAL SECURITY NUMBER:** \_\_\_\_\_

**DEPARTMENT NAME:** \_\_\_\_\_

*I understand that New York Medical College offers the following benefit plans on a contributory basis to eligible employees. I wish to participate in the plan(s) INDICATED below and authorize payroll reductions (pre-tax) or deductions (post-tax) for the plans I have elected.*

**INDICATE** your choices for benefits on the lines provided:

**FOR OFFICE USE ONLY**

**PPO** **CODES**

**MEDICAL / DENTAL EFF. DATE:** \_\_\_\_\_

**CARE PLUS PLAN (EMPIRE)**

Individual \_\_\_\_\_ (EE Only)  
Individual + 1 \_\_\_\_\_ (EE + 1)  
Family \_\_\_\_\_ (FAM)  
Waived Coverage \_\_\_\_\_ (WAIVED)

CP1 \_\_\_\_\_ Care Plus Plan (L1)  
CP2 \_\_\_\_\_ Care Plus Plan (L2)  
CP3 \_\_\_\_\_ Care Plus Plan (L3)  
CP4 \_\_\_\_\_ Care Plus Plan (L4)  
CP5 \_\_\_\_\_ Care Plus Plan (L5)  
CP6 \_\_\_\_\_ Care Plus Plan (L6)  
CP7 \_\_\_\_\_ Care Plus Plan (L7)  
CP8 \_\_\_\_\_ Care Plus Plan (L8)  
Part-Time \_\_\_\_\_

**EPO**

**OXFORD**

Individual \_\_\_\_\_ (EE Only)  
Individual + 1 \_\_\_\_\_ (EE + 1)  
Family \_\_\_\_\_ (FAM)  
Waived Coverage \_\_\_\_\_ (WAIVED)

OX1 \_\_\_\_\_ Oxford EPO (L1)  
OX2 \_\_\_\_\_ Oxford EPO (L2)  
OX3 \_\_\_\_\_ Oxford EPO (L3)  
OX4 \_\_\_\_\_ Oxford EPO (L4)  
OX5 \_\_\_\_\_ Oxford EPO (L5)  
OX6 \_\_\_\_\_ Oxford EPO (L6)  
OX7 \_\_\_\_\_ Oxford EPO (L7)  
OX8 \_\_\_\_\_ Oxford EPO (L8)  
Part-Time \_\_\_\_\_

**DENTAL PLANS (MET LIFE)**

**WAIVED MEDICAL** \_\_\_\_\_

1. **Enhanced (UCR)**  
Individual \_\_\_\_\_ (EE Only)  
Individual + 1 \_\_\_\_\_ (EE + 1)  
Family \_\_\_\_\_ (FAM)

DENHN \_\_\_\_\_ Enhanced Dental Plan

2. **Assistance (FEE)**  
Individual \_\_\_\_\_ (EE Only)  
Individual + 1 \_\_\_\_\_ (EE + 1)  
Family \_\_\_\_\_ (FAM)  
Waived Coverage \_\_\_\_\_ (WAIVED)

DASST \_\_\_\_\_ Assistance Dental Plan

**WAIVED DENTAL** \_\_\_\_\_

**VISION (OUTLOOK)**

Yes \_\_\_\_\_  
No \_\_\_\_\_

**VISION EFF. DATE:** \_\_\_\_\_

**INPUT DATE/INITIALS** \_\_\_\_\_

I acknowledge that I have been offered the coverages listed above for which I am (or may become) eligible and have indicated my choices. I understand that I will be enrolled in these plan(s) through the end of the plan year. I also understand that if I do not elect the contributory coverages now, but wish to participate at a later date (Open Enrollment or Life/Status Event), I may then be required to furnish, at my own expense, evidence of insurability satisfactory to the insurance provider.

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_