The University Corporation FlexCash Enrollment Form

Name	

- [ ] Newly Eligible Enrollment
- [ ] Annual Open Enrollment
- [ ] Change due to a Qualifying Event
- [ ] Cancellation

Plan Elections

☐	Cash in lieu of medical insurance	________	Enter $128.00 or none
☐	Cash in lieu of dental insurance	________	Enter $12.00 or none
	Monthly reimbursement	________	Enter total to be reimbursed

I certify that I am not covered by a TUC plan and that I am covered by another valid medical and/or dental plan (s). I certify that I will maintain coverage in this medical and/or dental insurance plan(s) on an ongoing basis and I agree to notify TUC Human Resources Department within 60 days if I lose coverage under the medical and/or dental insurance plan(s).

Medical Insurance Carrier Name ________ Policy Number ________

Dental Insurance Carrier Name ________ Policy Number ________

I have read and agree to the terms and conditions of the FlexCash Program as outlined on this form

Employee Signature ____________________ Date ____________________