



Office of Human Resources
Administrative and Business Services
University of Cincinnati
PO Box 210099
Cincinnati, Ohio, 45221-0099

University Hall
51 Goodman, Suite 340
513-556-6381

First 1000 Medical Plan Acknowledgement

I do hereby acknowledge I attended a First 1000 Medical Plan session with a benefits counselor on _____. I affirm I understand the coverage, benefit allowance, copayments, deductibles, out-of-pockets limits and other provisions of the First 1000 Medical Plan.

I certify the information I have furnished on this form is true, correct and complete to the best of my knowledge. Furthermore, I understand that falsifying benefit documents may be grounds for disciplinary action up to and including termination of employment.

I understand the University's benefit programs are subject to change. Information regarding these programs is available through the University's Benefits Office at 513-556-6381 or HRBEN@ucmail.uc.edu.

For the insurance under the Choice Benefits Program, I understand I may only change my medical plan during the plan (calendar) year and that my elections are irrevocable until the next annual enrollment period unless I experience a qualified status change as defined under IRS Section 125, and the change in medical plan is consistent with the qualified status change. If I experience a qualified status change, I must notify the University's Benefits Office within 31 days of the date of the qualified status change by completing and submitting the appropriate form(s).

I hereby affirm the aforesaid by signing this acknowledgement.

Name (print) : _____

Signature: _____

SSN : _____ **Date:** _____

