Reset Form

UNIVERSITY OF SOUTH CAROLINA
Human Resources

Carolina Rewards Orientation Worksheet (CROW)

Enrollment Type

Newly Hired/Newly Eligible

Special Eligibility Situation

Open Enrollment

IMPORTANT - Health Insurance Worksheet:
You must complete all sections of the CROW within 30 days of your hire date and submit it along with supporting documentation, if applicable, and all other enrollment forms (e.g. MoneyPlus Enrollment Form, if electing a spending account).

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1.	**Employee Information**			
SSN:	Name (Last, First, M.I.):			
Mailing Address:				
City:	State:	Zip:	County:	
Date of Birth:	Gender:	Marital Status:		
Home Phone:	Work Phone:	Primary Email:		
Covered By Medicare: (If yes, attach a copy of Medicare card(s).) Yes ◯ No ◯				
Premiums: Pre-Tax Deductions ◯ Post-Tax Deductions ◯				
Date of Hire:				
Is your date of hire the 1st working day of the month e.g., June 3, 2019? Yes ◯ No ◯				
Number of Pay Periods in a Year: 18 ◯ 24 ◯				
	If YES, do you want your benefits to start the 1st of the month you start working, e.g., June 1, 2019, **or** the 1st of the next month, e.g., July 1, 2019?			
	1st Day of the Month I Start Working ◯	1st Day of Next Month ◯		
Be mindful of your decision, as it may impact the amount of arrears USC collects for insurance premiums.				

2.	**Tobacco Certification**
a.	Choose **One** Regarding Tobacco Use:
◯	**Non-Tobacco User**: I certify that I am eligible for the Non-Tobacco User Premium by checking this box. By checking this box, I certify that all persons covered on my health insurance through PEBA are not currently using, and have not used, any tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last six months.
◯	**Tobacco User Premium**: I acknowledge that I will pay the Tobacco User Premium by checking this box. One or more persons covered on my health insurance through PEBA uses tobacco products in some form or I choose not to disclose my status as it relates to tobacco user.
3.	**Health Plan Election**
a.	Choose **One** Health Plan Option:
b.	If Enrolling, Choose Level of Coverage:

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4.	**Dental Plan Election**
a.	Choose a Dental Plan Option: Enroll ◯ Refuse ◯
b.	If Enrolling, Choose Level of Coverage:
c.	Dental Plus Plan: Yes ◯ No ◯
5.	**Vision Plan Election**
a.	Choose a Vision Plan Option: Enroll ◯ Refuse ◯
b.	If Enrolling, Choose Level of Coverage:

6. Optional Life Insurance

($10K - $500K, in $10K increments, not to exceed maximum guaranteed issue amount of three times salary rounded down. Coverage exceeding three times salary, up to $500K, requires evidence of insurability.)

I Elect Coverage ◯ Amount: | No Coverage ◯

7.	**Dependent Life Spouse Insurance**
a.	Choose a Dependent Life Spouse Option: $10,000 ◯ $20,000 ◯ No Coverage ◯
8.	**Dependent Life Child(ren) Insurance**
b.	Choose a Dependent Life Child Option: $15,000 ◯ No Coverage ◯
9.	**Supplemental Long-Term Disability (SLTD) Insurance**
a.	Choose a SLTD Plan Option: 90 Day ◯ 180 Day ◯ No Coverage ◯
b.	If Enrolling, Choose Your Level of Coverage:

10. MONEYPLUS Elections:

If you enroll in a Health Savings Account (Section C), you cannot enroll in a Medical Spending Account (Section A) but you may enroll in a Limited-use Medical Spending Account (Section D). There is a monthly fee of $2.32 for medical spending, dependent care, and limited-use medical spending accounts. There is a monthly fee of $1.00 for health savings accounts.

A. MEDICAL SPENDING ACCOUNT

New Enrollment ◯ Refuse ◯

Receive reimbursement for eligible medical expenses incurred by you, your family members, or both. The maximum allowable contribution is $2,700 annually.

Annual Amount: $_____

B. DEPENDENT CARE SPENDING ACCOUNT

New Enrollment ◯ Refuse ◯

Tax filing status, please check one and enter annual contribution amount.

Married, filing separately (Maximum - $2,500) $_____ Annual Amount

Single, head of household (Maximum - $5,000) $_____ Annual Amount

Married, filing jointly (Maximum -$5,000) $_____ Annual Amount

The contribution limit for highly compensated employees is $1,700. Highly compensated employees, as defined by the federal government, are those who make $120,000 or more.

C. HEALTH SAVINGS ACCOUNT

New Enrollment ◯ Refuse ◯

Select which type of State Health Plan Savings Plan coverage you have.

Individual Annual Amount $ _____ (Maximum - $3,500)

Family Annual Amount $ _____ (Maximum - $7,000)

Over 55 Catch-up (Additional $1,000) Annual Amount: $ _____

D. LINITED-USE MEDICAL SPENDING ACCOUNT

New Enrollment ◯ Refuse ◯

Receive reimbursement for eligible medical expenses incurred by you, your family members, or both. The maximum allowable contribution is $2,700 annually.

Annual Amount: $_____

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11. Dependent Coverage Information

DEPENDENT SSN	RELATIONSHIP	NAME (LAST, FIRST, M.I.)	GENDER (M/F)	DOB	HEALTH PLAN	DENTAL PLAN	VISION PLAN	FT STUDENT	INCAPACITATED CHILD	EMPLOYED BY STATE OF SC
					☐	☐	☐			☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐

12. Beneficiary Information

BASIC LIFE (BL) OPTIONAL LIFE (OL) (SELECT ONE OR BOTH)	BENEFICIARY SSN	NAME (LAST, FIRST, M.I.)	DATE OF BIRTH	RELATIONSHIP	PRIMARY/ CONTINGENT (P/C)

If Beneficiary is an Estate or Trust, Complete the Following:

Estate/Trust:	Address:
If Trust, Date Signed:	

This is not your enrollment form!

Upon receipt, your benefits counselor will enter the information you submitted on the CROW form into SC PEBA's insurance electronic enrollment system, MyBenefits. You will receive an email notification from SC PEBA regarding a pending transaction. Login to MyBenefits to review and certify the enrollment. If you have any corrections or changes, RETURN it electronically in MyBenefits and indicate the changes in the dialogue box. Your counselor will retrieve your returned transaction, make the changes and submit it back to you for final review and certification.