BENELECT 2018 ENROLLMENT FORM

PERSONAL INFORMATION

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<th>First name</th>
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Name

Address

City | State | Zip Code

Home/Cell Phone | Business Phone | E-mail

Birth Date | Gender: M F | Married: Y N | Date of Marriage

DEPENDENT INFORMATION (Dependent verification documents must be submitted with enrollment form)

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<th>Relationship</th>
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<th>Birth Date (Mo Day Yr)</th>
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<th>Soc Sec No.</th>
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Please select an insurance carrier and coverage level for each benefit, or select Waive for no coverage.
The amount you pay depends on the university’s contribution. See separate price sheet for details.

HEALTH COVERAGE

- Election of Employee+Spouse or Family requires completion of the Working Spouse Premium form.

- [ ] Anthem PPO
- [ ] MMO SuperMed PPO
- [ ] MMO CLE-Care HMO
- [ ] Anthem High Deductible
- [ ] Waive Medical

Level of coverage:

- [ ] Employee Only
- [ ] Employee + Child(ren)
- [ ] Employee + Spouse/Equivalent*
- [ ] Family*

High Deductible Plan only:

- [ ] Health Savings Account
- [ ] Waive Health Savings Account

Monthly pledge:

MEDICARE AND OTHER INSURANCE INFORMATION

Complete ONLY if you have selected coverage for yourself or your dependents through Benelect medical and/or dental

Do you or any of your dependents have other health or dental coverage?

- [ ] Yes
- [ ] No

If yes, complete below

Name of policy holder

Name and address of insurance company

Policy No.

Effective Date

Coverage Type

DENTAL COVERAGE

- [ ] DenteMax
- [ ] School Dental Med Comprehensive
- [ ] Waive Dental

Level of coverage:

- [ ] Employee Only
- [ ] Employee + Child(ren)
- [ ] Employee + Spouse/Equivalent
- [ ] Family
VISION COVERAGE

- □ VSP  Level of coverage: □ Employee Only □ Employee + Child(ren) □ Employee + Spouse/Equivalent □ Family
- □ Union Eye Care  Level of coverage: □ Employee Only □ Employee + 1 □ Family
- □ Waive Vision

FLEXIBLE SPENDING ACCOUNT PLANS
Flexible spending account minimum annual contribution is $120; maximum of $2,650 per year for Health Care, $5,000 for Dependent Care. Unspent dollars in calendar year are forfeited. You cannot contribute to the health care flexible spending account if you participate in the Anthem High Deductible health plan.

- □ Health Care Flexible Spending Account  Monthly pledge ________________  □ Waive Medical FSA
- □ Dependent Care (annual maximum $2,500 if married filing separate tax returns)  Monthly pledge ________________  □ Waive Dependent FSA

LIFE AD/D COVERAGE
Please mark your selection. Medical evidence of insurability may be required for supplemental elections. Maximum coverage allowed is 3 x salary, but not more than $500,000.

- □ 1X □ 1.5X □ 2X □ 2.5X □ 3X □ 50,000 □ Waive Supplemental Life

DEPENDENT LIFE (Voluntary After-tax Benefit)

- □ $5,000 Spouse/$1,000 Child(ren)  1.00/month □ $10,000 Spouse/$2,000 Child(ren)  2.00/month
- □ Waive Dependent Life

PREPAID LEGAL (Voluntary After-tax Benefit)

- □ Hyatt Legal Plan  $18.25/month  □ Waive Prepaid Legal

EMPLOYEE SIGNATURE

I understand that by signing and submitting this form within the first 30 days of employment, I am making a binding election concerning my benefits until such time as I elect new coverage and sign a new form.

Signature ___________________________ Date ___________________________

Return completed enrollment form and dependent verification documents to Benefits Administration, 320 Crawford Hall, LC 7047.

CASE BENEFITS ADMINISTRATION

Date of hire ___________________________ Coverage effective date ___________________________

Benefits Representative Signature ___________________________ Date ___________________________