

BENELECT 2018 ENROLLMENT FORM

PERSONAL INFORMATION

Name: *First name* _____ *Last name* _____ Empl ID _____
 Soc Sec No. _____
 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)

Relationship	Last (only if different)	First	Birth Date (Mo Day Yr)	Gender	Soc Sec No.	WSp Pre	Dep Ver	Init
Spouse or Equiv				M F				
				M F				
				M F				
				M F				
				M F				
				M F				

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 Ee+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 _____