BENELECT 2019 ENROLLMENT FORM

PERSONAL INFORMATION

First name *Last name* Empl ID _____

Name _____ 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

CASE WESTERN RESERVE UNIVERSITY EST. 1826

Rev 122018

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 $2,700 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**