BENELECT 2021 ENROLLMENT FORM

PERSONAL INFORMATION

Name Empl ID

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. Do NOT send forms containing sensitive information via email or fax.

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.

☐ MMO SuperMed PPO ☐ MMO CLE-Care HMO ☐ MMO SuperMed High Deductible ☐ Waive Medical

Level of coverage: ☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse/Equivalent* ☐ Family*

High Deductible Plan only: ☐ Health Savings Account Monthly pledge $_____ ☐Waive Health Savings Account

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 coverage? ☐ Yes ☐ No If yes, complete below

Name of policy holder	Name and address of insurance company	Policy No.	Effective Date	Coverage Type

CASE WESTERN RESERVE UNIVERSITY EST. 1826

DENTAL COVERAGE

☐ DenteMax ☐ School Dental Medicine Comprehensive ☐ Waive Dental

Level of coverage: ☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse/Equivalent ☐ Family

VISION COVERAGE

☐ VSP ☐ Waive Vision

Level of coverage: ☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse/Equivalent ☐ Family

FLEXIBLE SPENDING ACCOUNT PLANS

Flexible spending account minimum annual contribution is $120; maximum of $2,750 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 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
HR Service Center, 320 Crawford Hall, LC 7047.

CWRU BENEFITS ADMINISTRATION

Date of Hire _____ Coverage Effective Date _____

☐ Life Insurance Beneficiary form received

Benefits Representative Signature Date