# 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

# Working Spouse Premium Election Form

The Working Spouse Premium applies if you elect to cover a spouse/domestic partner on your Benelect medical insurance plan who has access to group health insurance coverage through another employer. The premium offsets the university's cost to provide health insurance to those spouses/domestic partners who could obtain coverage from another employer.

_____ _____

*Employee Name (please print)* *Employee ID*

☐ Yes, my spouse/domestic partner has access to group health insurance coverage from another employer. I understand that a $100 per month premium will be charged for covering him/her on my Benelect medical insurance plan.

☐ No, my spouse/domestic partner does not have access to group health insurance coverage from another employer because he/she (*please check one*):

- ☐ is unemployed
- ☐ is self-employed
- ☐ is employed, but does not qualify for or is not offered group health insurance coverage
- ☐ is employed in a benefits eligible position by Case Western Reserve University
- ☐ is retired

This Election is effective as of ____ /_____/ _____

I certify that to the best of my knowledge my election is an accurate reflection of my personal facts and circumstances. I understand that any false statements made on this form as it relates to spousal health insurance information can lead to disciplinary action. I also understand that if my spouse's group health insurance status changes, it is my responsibility to notify Benefits Administration within 30 days of such change.

_____ _____

*Signature* *Date*

*Return completed form to askHR@case.edu*

*Benefits Administration, 320 Crawford Hall, LC 7047.*

FOR BENEFITS ADMINISTRATION USE ONLY

Benefits Representative Signature _____ Date _____

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## Supplemental Life and AD/D

*The benefit is reduced by 35 percent of the original amount at age 65, and further reduced to 50 percent at age 70.*

| Your Age | Coverage |
|---|---|
| Under 30 | 0.02 |
| 30-34 | 0.03 |
| 35-39 | 0.03 |
| 40-44 | 0.04 |
| 45-49 | 0.06 |
| 50-54 | 0.10 |
| 55-59 | 0.17 |
| 60-64 | 0.24 |
| 65-69 | 0.37 |
| 70 and over | 0.84 |

**Calculate cost of premium**

Amount of insurance (in thousands) = _____

Subtract Case's 20,000 _____ - 20

Total insurance _____

Multiply by rate _____

Premium = _____

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**IMPUTED INCOME**

Life insurance is a tax-free benefit in amounts up to $50,000. The Internal Revenue Service requires you to pay income tax on the value of any amount exceeding $50,000. The IRS-determined value is called "imputed income" and is calculated from the government's "Uniform Premium Table I."

| AGE | COST per $1,000 for 1 month |
|---|---|
| Under age 25 | .05 |
| 25 to 29 | .06 |
| 30 to 34 | .08 |
| 35 to 39 | .09 |
| 40 to 44 | .10 |
| 45 to 49 | .15 |
| 50 to 54 | .23 |
| 55 to 59 | .43 |
| 60 to 64 | .66 |
| 65 to 69 | 1.27 |
| 70 and Over | 2.06 |

MEDMUTUAL LIFE™
A Medical Mutual Company
15885 W. Sprague Road, Strongsville, Ohio 44136-1772

# Beneficiary Designation Form

Telephone: 866-925-2542
Fax: 440-878-6916
Email Address: Claims@MedMutualLife.com

**Group Number**
227922

☐ Initial ☐ Change

| Insured's Name | Social Security No. | Date of Birth |
|---|---|---|
| | | / / |
| Group Name<br>Case Western Reserve University | Marital Status (check one)<br>☐ Married ☐ Widowed ☐ Single ☐ Divorced | |

**COVERAGE TYPE** – The Beneficiary designation will apply to all death benefits for the above named Insured, unless they designate otherwise by checking a specific coverage:

☐ Basic Term Life ☐ Basic AD&D ☐ Supp Life ☐ Supp AD&D ☐ Voluntary Life ☐ Voluntary AD&D ☐ All

## Definitions:

**Primary Beneficiary:** The primary beneficiary is the person(s) you name to receive death benefits. You may name more than one beneficiary. ***If you specify benefit percentages, the total must equal 100%.*** If you do not specify benefit percentages, proceeds will be paid in equal shares to the primary beneficiaries who survive you.

**Contingent Beneficiary:** The contingent beneficiary is the person(s) you name to receive death benefits if no primary beneficiary survives you. ***If you specify benefit percentages, the total must equal 100%.***

**PRIMARY BENEFICIARY(IES):**

In accordance with the provisions of the Policy and/or Certificate, I hereby request the benefits payable for loss of life to be issued as follows:

| First Name | Last Name | Date of Birth | Relationship | Benefit % |
|---|---|---|---|---|
| | | / / | | |
| | | / / | | |
| | | / / | | |
| | | / / | | |

**CONTINGENT BENEFICIARY(IES):**

| First Name | Last Name | Date of Birth | Relationship | Benefit % |
|---|---|---|---|---|
| | | / / | | |
| | | / / | | |
| | | / / | | |
| | | / / | | |

I hereby revoke all former beneficiary designations and I reserve the right to make further changes at any time, subject to Policy provisions.

Signature of Insured _____ Date Signed _____

**Important Note for Married Employees:** If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, and you name someone other than your spouse as primary beneficiary, your spouse's consent will be necessary to allow your spouse to waive his or her rights to any community property interest in the benefits. We have provided a space below for your spouse's signature. Payment of this benefit may be delayed or disputed unless your spouse signs below.

**Spousal Consent for Community Property States Only:** I hereby consent to the Primary Beneficiary designated by my spouse and understand that this consent supersedes any prior spousal consent under this plan.

Signature of Spouse _____ Date Signed _____

# Dependent Verification Document Requirements

*You must show the appropriate documents from the list below to Benefits Administration within 30 days of hire or qualifying change of status event.*

| Dependent Status | Required Documentation |
|---|---|
| Spouse | • Marriage certificate issued by county registrar with appropriate signatures<br>or<br>• Immigration papers that identify employee-spouse relationship<br>or<br>• Top half of current Federal tax form 1040 identifying employee-spouse relationship |
| Domestic Partner | • Domestic partner affidavit (and any other documents required by Human Resources) |
| Dependent child by birth | • Birth certificate that includes parent names<br>or<br>• Immigration papers that identify employee-child relationship<br>or<br>• Legal paperwork requiring dependent coverage<br>or<br>• Top half of current Federal tax form 1040 identifying employee-child relationship |
| Dependent child by adoption | • Certified court approved adoption papers<br>or<br>• Placement letter from court/adoption agency<br>or<br>• Birth certificate that includes adoptive parent names |

| | |
|---|---|
| Dependent child by custody or guardianship | • Certified court ordered custody/guardianship papers |
| Dependent stepchild | • Birth certificate that includes parent names<br>or<br>• Immigration papers that identify parent-child relationship<br>AND<br>• Marriage certificate issued by county registrar with appropriate signatures<br>or<br>• Legal paperwork requiring dependent coverage<br>or<br>• Immigration papers that identify employee-spouse relationship<br>or<br>• Top half of current Federal tax form 1040 identifying employee-spouse relationship |
| Disabled dependent child age 26 and over | In addition to the verification of dependent status described above, you must also provide:<br>• Social Security disability award |

# 2021 Wellness Opportunities

New employees who add Benelect medical plan coverage for 2021 can receive a $25 per month Wellness Incentive* by completing the following three Wellness Activities **within 30 days of their start date.**

- **Health Risk Assessment from WebMD – (https://webmdhealth.com/cwru)**
  - Register to create an account using your first name, date of birth and Network ID
  - Complete the assessment
- **AND Complete TWO of these THREE activities**
  - **Biometric Screenings with Quest Diagnostics (https://my.questforhealth.com)**
    - Create an account using registration code: CWRU
    - Schedule an appointment at one of the Quest Screening Centers or use the Physician Results Form (PRF) also available on the Quest site.
    - All standard HIPAA rules apply
- **Tobacco Attestation Form**
  - Complete the form in this NEW HIRE package
- **Primary Care Provider Attestation Form**
  - Complete the form in this NEW HIRE package

*Please note: it may take seven to ten (7-10) days for new employees to gain access to the systems for scheduling a biometric screening.*

Employees can view completed Wellness Activities by logging into HCM and clicking on the Wellness Tile, then choosing the Wellness Summary from the options in the left column.

**Additional Wellness Program Incentives* for 2021**

Faculty and staff who have completed the three wellness activities listed above can receive up to an additional $200 ($100 per program) in 2021 by completing various Wellness Programs. Information about 2021 Wellness Programs can be found on the Wellness website at **www.case.edu/wellness/facultystaff.**

**Notice of Reasonable Alternative Standard:** If a medical condition makes it unreasonably difficult for you to achieve the standards for the incentive under this program, or if it is medically inadvisable as determined by your physician or health care provider for you to attempt to achieve the standards for the incentive under this program, contact Elizabeth Click at erc10@case.edu to request a reasonable alternative standard, and we will work with you to provide another way to qualify for the incentive. Recommendations of your physician or health care provider will be considered and accommodated in developing an alternative standard that is reasonable in light of your health status.

*The monthly Wellness Incentive and the Wellness Program Incentive(s) are taxable.

**2021 Tobacco Attestation Form**

One of the requirements to be eligible for the 2021 Wellness Premium Incentive – a $25 monthly incentive that is available for faculty and staff with medical coverage through CWRU and who complete the Health Risk Assessment and two of three other wellness activities - is this Tobacco Attestation Form in which you indicate whether or not you currently use tobacco.

The Tobacco Attestation Form requires you to attest to your current tobacco use status by checking one of the responses below.

Note: By completing this form, you are authorizing your response to be shared with appropriate offices within the University that are responsible for administering benefits, the Wellness program, and the Wellness Incentive.

Failure to accurately attest to your tobacco usage status on the attestation form and/or failure to report the resumption of your tobacco use after completing this attestation will constitute an act of dishonesty, will disqualify you from eligibility for participation in the CWRU Wellness Program and Wellness Incentive opportunity, and will result in appropriate disciplinary action.

If you are currently a tobacco user, completion of a tobacco cessation program is required prior to you receiving the monthly Wellness Incentive. The University offers an on-line coaching program called LivingFree which all benefits-eligible faculty and staff can access via the wellness website. The QuitLine program, an individual telephonic coaching program, is also offered free of charge to all benefits-eligible faculty and staff (call 1-800-QUIT-NOW). Eight weeks of free nicotine replacement therapy is offered with the QuitLine program. Upon completion of a program, a medical plan participant may bring documentation of program completion to the Benefits Department or notify Elizabeth Click, erc10@case.edu. If you completed the Health Risk Assessment and one of the other wellness activities (e.g., Biometric Screening program or Primary Care Provider Attestation Form, you will then be able to obtain the 2021 Wellness Program Incentive effective retroactively to the start of the plan year (January)). The retroactive payment will be provided in a lump sum payment, with the remainder of the Wellness Premium Incentive allocated monthly. The incentive is taxable. If you have questions, please contact mxd490@case.edu.

**Notice of Reasonable Alternative Standard**: If a medical condition makes it unreasonably difficult for you to achieve the standards for the incentive under this program, or if it is medically inadvisable as determined by your physician or health care provider for you to attempt to achieve the standards for the incentive under this program, contact erc10@case.edu to request a reasonable alternative standard, and we will work with you to provide another way to qualify for the incentive. Recommendations of your physician or health care provider will be considered and accommodated in developing an alternative standard that is reasonable in light of your health status.

"Tobacco" refers to any product containing tobacco in any form. Tobacco products include, but are not limited to, cigarettes (clove, bidis, kreteks, ecigarettes), cigars and cigarillos, pipes, all forms of smokeless tobacco, and any other smoking devices that use tobacco such as hookahs, and any other existing or future smoking, tobacco or tobacco-related products. This does not include Nicotine Replacement Therapy (NRT) products used as part of a tobacco cessation program or effort.

◯ I DO NOT smoke or use tobacco products.
◯ I DO smoke or use tobacco products.

Employee Name (please print): _____
Employee Signature: _____
Date completed (mm/dd/yyyy): _____

**2021 Primary Care Provider (PCP) Attestation Form**

One of the requirements to be eligible for the 2021 Wellness Premium Incentive – a $25 monthly incentive that is available for faculty and staff with medical coverage through CWRU and who complete the Health Risk Assessment and two of three other wellness activities - is this PCP Attestation Form.

The PCP Attestation Form requires you to attest that you have a primary care provider and you have had or will have a primary care visit between July 1, 2020 and June 30, 2021.

A Primary Care Provider (PCP) is defined as a physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) or nurse practitioner (N.P.) , or physician assistant (P.A.) that takes care of the health care needs of patients and/or helps coordinate care and provides access to specialist services for patients. PCPs are seen for undiagnosed conditions as well as chronic and major health conditions.

Note: By completing this form, you are authorizing your response to be shared with appropriate offices within the University that are responsible for administering benefits, the Wellness program, and the Wellness Premium Incentive.

Failure to accurately attest to will constitute an act of dishonesty, will disqualify you from eligibility for participation in the CWRU Wellness Program and Wellness Incentive opportunity, and will result in appropriate disciplinary action.

**Notice of Reasonable Alternative Standard**: If a medical condition makes it unreasonably difficult for you to achieve the standards for the incentive under this program, or if it is medically inadvisable as determined by your physician or health care provider for you to attempt to achieve the standards for the incentive under this program, contact erc10@case.edu to request a reasonable alternative standard, and we will work with you to provide another way to qualify for the incentive. Recommendations of your physician or health care provider will be considered and accommodated in developing an alternative standard that is reasonable in light of your health status.

◯ I attest that I have met with, and/or have an upcoming appointment to meet with, my Primary Care Provider (PCP) for a health care appointment at least once between the dates of July 1, 2020 and June 30, 2021.

Employee Name (please print): _____

Employee Signature: _____

Date completed (mm/dd/yyyy): _____