BENELECT ENROLLMENT FORM
2023

PERSONAL INFORMATION

Name:				EMPLID:
Address:				
City:	State:			Zip:
Home Phone:	Work Phone:			Email:
Birth Date:	Gender:	M	F	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	Gender		Soc. Sec. No.	Dep Ver
Spouse/Equiv				M	F		
				M	F		
				M	F		
				M	F		

MEDICARE AND OTHER INSURANCE INFORMATION: Complete ***ONLY*** if you or any of your dependents have other health coverage ***AND*** you plan to select coverage for yourself or your dependents through Benelect medical and/or dental.

Name of policy holder	Name and address of insurance company	Policy Number	Effective Date	Coverage type

Select insurance carrier/plan 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 costs.

HEALTH COVERAGE *Election of EE+Spouse or Family requires completion of the Working Spouse premium forms.

Choose your plan:

- ☐ SuperMed PPO
- ☐ Medical Mutual High Deductible Health Plan
- ☐ CLE Care HMO
- ☐ WAIVE

Choose your coverage level:

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

DENTAL COVERAGE

Choose your plan:

- ☐ Superior Dental Care
- ☐ CWRU School of Dental Medicine
- ☐ WAIVE

Choose your coverage level:

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Equivalent
- ☐ Family

VISION COVERAGE

Choose your plan:

- ☐ VSP
- ☐ WAIVE

Choose your coverage level:

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Equivalent
- ☐ Family

CASE WESTERN RESERVE UNIVERSITY EST. 1826

LIFE INSURANCE COVERAGE

Medical evidence of insurability may be required for supplemental elections.

SUPPLEMENTAL LIFE AND AD/D COVERAGE
(Maximum coverage allowed is 3 x salary, but not more than $500,000.)

- ☐ 1.0X
- ☐ 1.5X
- ☐ 2.0X
- ☐ 2.5X
- ☐ 3.0X
- ☐ $50,000
- ☐ WAIVE

DEPENDENT LIFE (After-tax benefit)

- ☐ $5,000 Spouse/$1,000 Child(ren) | $1.00/month
- ☐ $10,000/Spouse/$2,000 Child(ren) | $2.00/month
- ☐ WAIVE

PREPAID LEGAL (After-tax benefit)

- ☐ MetLife Legal
- ☐ WAIVE

SAVINGS ACCOUNTS

Flexible Spending Account (FSA)

FSA minimum annual contribution is $120; maximum of $3,050 per year for Health Care

- ☐ Health Care Flexible Spending Account
- _____ Monthly pledge
- ☐ WAIVE

Dependent Care Spending Account (DCSA)

DCSA maximum is $5,000 per year for individuals; $2,500 per year if married filing separate tax returns

- ☐ Dependent Care Flexible Spending Account
- _____ Monthly pledge
- ☐ WAIVE

Health Savings Account

Available only if enrolling in the High Deductible Health Plan. The annual maximum is $3,850 per year for individuals; $7,750 per year for families

- ☐ Health Savings Account
- _____ Monthly pledge
- ☐ WAIVE

PARTICIPANT 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 associated carrier applications to HR Service Center, 320 Crawford Hall, LC 7047

CWRU BENEFITS ADMINISTRATION

- _____ Date of Hire
- ☐ Life Insurance Beneficiary Form received
- ☐ Wellness Incentive Forms received
- ☐ Meritain FSA/DCSA entered
- _____ Benefits Coordinator Initial Complete

- _____ Coverage Effective Date
- ☐ WSP Election Form received
- ☐ VSP entered
- ☐ BenefitWallet entered
- _____ Date Entry Complete

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 = _____

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 Case Western Reserve University	Marital Status (check one) ☐ 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 or • Immigration papers that identify employee-spouse relationship or • 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 or • Immigration papers that identify employee-child relationship or • Legal paperwork requiring dependent coverage or • Top half of current Federal tax form 1040 identifying employee-child relationship
Dependent child by adoption	• Certified court approved adoption papers or • Placement letter from court/adoption agency or • 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 or • Immigration papers that identify parent-child relationship AND • Marriage certificate issued by county registrar with appropriate signatures or • Legal paperwork requiring dependent coverage or • Immigration papers that identify employee-spouse relationship or • 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: • Social Security disability award