BENELECT ENROLLMENT FORM
2024

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
Department of Human Resources

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
- ☐ 2.5Xo
- ☐ 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 $3,200 per year for Health Care

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

Dependent Care Spending Account (DCSA)

DCSA maximum is $2,500 per year for individuals; $5,000 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 $4,150 per year for individuals; $8,300 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

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 _____

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*

☐ 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.

☐ 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

☐ My spouse is gaining medical outside of Case and I would like to **stop** having the $100 premium charged.
A Change of Status **and** proof of gain of coverage is attached.

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 _____

CASE WESTERN RESERVE UNIVERSITY EST. 1826

2024 Wellness Opportunities

New employees who add Benelect medical plan coverage for 2024 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 2024

Faculty and staff who have completed the three wellness activities listed above can receive up to an additional $200 ($100 per program) in 2024 by completing various Wellness Programs. Information about 2024 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.

2024 Primary Care Provider (PCP) Attestation Form

One of the requirements to be eligible for the 2024 Wellness 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, 2023 and June 30, 2024.

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 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, 2023 and June 30, 2024.

Employee Name (please print): _____

Employee Signature: _____

Date completed (mm/dd/yyyy): _____

2024 Tobacco Attestation Form

One of the requirements to be eligible for the 2024 Wellness 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 offered free of charge to all benefits-eligible faculty and staff using one of the university's Medical Mutual medical plans. Four weeks of free nicotine replacement therapy is offered with the QuitLine program. Upon completion of a program, a medical plan participant may send documentation of program completion to 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 2024 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 Incentive allocated monthly. The incentive is taxable. If you have questions, please contact erc10@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): _____