BENELECT ENROLLMENT FORM
2025

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
- _____ Annual 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
- _____ Annual 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
- ☐ Healthy Equity entered
- _____ Date Entry Complete