

BENELECT 2012 ENROLLMENT FORM

PERSONAL INFORMATION

Empl ID _____

Name _____ Soc Sec No. _____

Address _____

City _____ State _____ Zip Code _____

Home 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)

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.

Anthem PPO
 MMO SuperMed PPO
 Kaiser HMO
 Anthem High Deductible
 Waive Medical

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

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

Kaiser only: Employee's Primary Care Physician (PCP) Name: _____ PCP ID: _____

Kaiser only: (circle one: spouse / dependent) PCP Name: _____ PCP ID: _____

Kaiser only: (circle one: spouse / dependent) PCP Name: _____ PCP ID: _____

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 or dental coverage? Yes No If yes, complete below

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



DENTAL COVERAGE DenteMax School Dental Med Comprehensive Waive Dental*Level of coverage:* Employee Only Employee + Child(ren) Employee + Spouse/Equivalent Family**VISION COVERAGE** VSP*Level of coverage:* Employee Only Employee + Child(ren) Employee + Spouse/Equivalent Family Union Eye Care*Level of coverage:* Employee Only Employee + 1 Family Waive Vision**FLEXIBLE SPENDING ACCOUNT PLANS**

Flexible spending account minimum annual contribution is \$120; maximum of \$5,000 per year. Unspent dollars in calendar year are forfeited. You cannot contribute to the health care flexible spending account if you participate in the Anthem 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)

\$0.50/month

 \$10,000 Spouse/\$2,000 Child(ren)

\$1.00/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
Benefits Administration, 224 Crawford Hall, LC 7047.***

CASE BENEFITS ADMINISTRATION

Date of hire _____

Coverage effective date _____

Benefits Representative Signature _____

Date _____