WASHINGTON AND LEE UNIVERSITY

2017/2018 BENEFITS ENROLLMENT FORM

Please complete all applicable fields, sign and return form to Human Resources in-person, through campus mail, by fax to 540-458-8060 or through US mail to 204 W. Washington Street, Lexington, VA 24450. If you have any questions, please contact Kim Austin at 540-458-8921 or kaustin@wlu.edu

Effective Date of Coverage: **Email Address :**_____

Personal Information			
Employee's Name:		Social Security Number:	
Mailing address:		Date of Hire:	
		Home Phone:	Cell Phone:
City:	State:	Zip Code:	
Date of Birth:	Sex ☐ Female ☐ Male	Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership	

If you enroll your domestic partner in health or dental below, you must also complete a Declaration of Domestic Partnership on the HR website at http://www.wlu.edu/human-resources/benefits/about-our-benefits-program/domestic-partner-benefits.

MEDICAL PLAN: ENROLLMENT ELECTION INFORMATION (Pre-Tax)

Anthem Medical / Rx (Check here if enrolling in medical OR complete medical waiver section.)

Anthem BCBS KeyCare PPO Plan	Monthly	Bi-Weekly
☐ None / Waive*	$0.00	$0.00
☐ Employee	$153.56	$76.78
☐ Employee + One	$345.51	$172.76
☐ Employee + Family	$399.13	$199.57

ENROLLMENT TIP:
To locate participating providers, call Anthem BCBS at 800-451-1527 or visit http://www.anthem.com

Employees paid over less than 12 months will have a higher rate per pay period.

MEDICAL PLAN: WAIVE OR DROP MEDICAL COVERAGE

Please complete this section of you are waiving medical coverage. You MUST check at least one box below to indicate your reason and complete the Carrier Name and Group ID Number below.

☐ I have group medical insurance through my spouse's employer or my parents' plan. ☐ I have medical insurance through Medicare. ☐ Other:

☐ I am covered under a stand-alone medical policy (not through a group). ☐ I do not wish to have any medical coverage (no other coverage).

Carrier Name: Group ID Number:

DENTAL PLAN: ENROLLMENT ELECTION INFORMATION (Pre-tax)

UCCI Dental Program

	CORE PLAN			BUY-UP PLAN	
	Monthly	Bi-Weekly		Monthly	Bi-Weekly
☐ Employee	$0.00	$0.00	☐ Employee	$20.57	$10.29
☐ Employee + One**	$24.01	$12.01	☐ Employee + One **	$56.00	$28.00
☐ Employee + Family**	$61.27	$30.64	☐ Employee + Family**	$106.11	$53.06

ENROLLMENT TIP:
To locate a participating dentist, call United Concordia at 800-332-0366 or visit http://www.ucci.com

If enrolling your dependents for dental, they must be enrolled in the same dental plan.

I do not want to enroll in dental insurance coverage (Check here to decline dental) ☐

DEPENDENT INFORMATION: MEDICAL / DENTAL PLANS

Please complete the information requested below for all eligible dependent family members who you enroll in health and dental. Note: **Your children can be covered through the end of the month in which they reach age 26 regardless of their student or marital status.**

(A)dd/New (C)hange (R)emove	First Name	Middle Initial	Last Name	SSN	DOB	Relationship	Gender	Plans Covered (Medical, Dental and/or Voluntary Vision)	Disabled Dependent
						SELF	☐M ☐F	☐M ☐D ☐VV	
						SPOUSE	☐M ☐F	☐M ☐D ☐VV	
						DOMESTIC PARTNER	☐M ☐F	☐M ☐D ☐VV	
						CHILD	☐M ☐F	☐M ☐D ☐VV	☐Y ☐N
						CHILD	☐M ☐F	☐M ☐D ☐VV	☐Y ☐N
						CHILD	☐M ☐F	☐M ☐D ☐VV	☐Y ☐N
						CHILD	☐M ☐F	☐M ☐D ☐VV	☐Y ☐N
						CHILD	☐M ☐F	☐M ☐D ☐VV	☐Y ☐N
						CHILD	☐M ☐F	☐M ☐D ☐VV	☐Y ☐N

FLEXIBLE SPENDING ACCOUNTS (Pre-Tax)

All full-time and part-time benefit-eligible employees can participate in the Flexible Spending Accounts Program. You can elect to deposit money on a pre-tax basis into either a Health Care Spending Account or into a Dependent Care Spending account, or both. The choice can be made once each plan year and cannot be changed during the plan year EXCEPT in the event of certain life-status changes. At the end of the Plan Year, any money not used, up to $500 will be carried over into the next Plan Year. **Please enroll or waive participation in the boxes below.**

Flexible Spending Accounts	
Health Care Flexible Spending Accounts: No minimum; maximum of $2,600 annually **Dependent Care Flexible Spending Accounts: No minimum; maximum of $5,000 annually (per family)** For additional information on FSA's, visit www.flex-admin.com. Annual election amounts will be deducted in equal installments from paychecks throughout the year.	
Health Care Flexible Spending Account ☐ **NONE** ☐ **ELECTING** **$** **Annual Amount (July - June)**	**Dependent Care Flexible Spending Account** ☐ **NONE** ☐ **ELECTING** **$** **Annual Amount (July – June)**

BASIC LIFE INSURANCE (Pre-tax)

All eligible, full-time employees can purchase a pre-tax Basic Life Insurance policy equal to 2 times base salary (not including bonuses, overtime or earnings for more than 40 hours per week). The minimum benefit is $50,000 and the maximum benefit is $400,000. Part-time benefit-eligible employees can elect $10,000. You and the University each pay 50% of the premium.

☐ I do not wish to have basic group life insurance under the program sponsored by Washington and Lee University, or pay the cost for such insurance. If I wish to become insured for basic group life insurance in the future, I understand that I may be required to furnish evidence of insurability and will not be insured unless and until my application is approved by the insurance company.

☐ **Yes,** I would like to purchase Basic Life Insurance. Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Primary Beneficiaries				
Primary Beneficiary's Name	***Relationship to Employee***	***Social Security Number***	***Date of Birth***	***% Share (total must equal 100%***
Contingent Beneficiaries				
Contingent Beneficiary's Name	***Relationship to Employee***	***Social Security Number***	***Date of Birth***	***% Share (total must equal 100%***

SUPPLEMENTAL LIFE INSURANCE (Post-tax)

If you purchase Basic Life Insurance, then you may also purchase Supplemental Life Insurance for additional protection, for yourself, your spouse and eligible dependents. Supplemental employee costs are based on your age and spouse costs are based on the spouse's age. *(See attached Grid to calculate the cost).* If you elect to waive supplemental life insurance when you first become eligible, your next opportunity to enroll will be during the next annual open enrollment and that election of employee or spouse supplemental life will be subject to evidence of insurability (health questionnaire).

EMPLOYEE

You can select in units of $10,000. The maximum is $300,000. The guaranteed coverage amount for you (if you apply within 31 days of employment) is the lesser of 3 times your annual salary or $100,000. If you elect more than the guaranteed amount you will need to submit evidence of insurability (health questionnaire). Please contact our office for this form.

PURCHASE AMOUNT REQUESTED *(In $10,000 increments)*	***Monthly COST*** ***(See attached Employee Grid to calculate cost)***
☐ *NONE* ☐ *$*	*$*

SPOUSE

You can select in units of $5,000. The maximum is $150,000. The guaranteed coverage amount for your spouse (if you apply within 31 days of employment) is $20,000. If you elect more than the guaranteed amount your spouse will need to submit evidence of insurability (health questionnaire). Please contact our office for this form.

PURCHASE AMOUNT REQUESTED *(In $5,000 increments)*	***Monthly COST*** ***(See attached Employee Grid to calculate cost)***
☐ *NONE* ☐ *$*	***$***

DEPENDENT CHILDREN (who are unmarried and 15 days to 25 years)

Coverage can be purchased in $2,000 increments to a maximum of $10,000. The term child means a child born to your or legally adopted by you. It also means a stepchild, including a domestic partner's child, living with you.

PURCHASE AMOUNT REQUESTED *(In $2,000 increments)*	***Monthly COST*** ***(See attached Employee Grid to calculate cost)***
☐ *NONE* ☐ *$*	***$***

Dependent Information: Supplemental Life Insurance

Spouse Name: _____ ***Birth Date:*** _____

Spouse Social Security Number:_____

Child Name: _____ ***Birth Date:*** _____

Child Social Security Number:_____

Child Name: _____ ***Birth Date:*** _____

Child Social Security Number:_____

Child Name: _____ ***Birth Date:*** _____

Child Social Security Number:_____

Child Name: _____ ***Birth Date:*** _____

Child Social Security Number:_____

Note: All eligible children in a family must be insured for the same amount. One rate applies for all eligible children in a family.

Beneficiaries: YOU are, by default, the beneficiary for any spouse or dependent children's policies. You can designate the beneficiaries for your supplemental policy.

☐ I elect to designate the same beneficiaries for my supplemental policy as I chose for my Basic Life Insurance policy immediately above.

☐ I elect the following beneficiaries. Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares.

Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).:

Primary Beneficiaries				
Primary Beneficiary's Name	***Relationship to Employee***	***Social Security Number***	***Date of Birth***	***% Share (total must equal 100%***
Contingent Beneficiaries				
Contingent Beneficiary's Name	***Relationship to Employee***	***Social Security Number***	***Date of Birth***	***% Share (total must equal 100%***

SUPPLEMENTAL LIFE INSURANCE RATES

The monthly cost of insurance for you and your spouse/domestic partner will depend on your ages and the amount of insurance you wish to purchase. As shown in the following chart, the cost of insurance increases with the age of the insured. This information is to assist you with calculating the cost of the amount of additional life insurance you wish to purchase.

AGE RANGE	Employee & Spouse/Domestic Partner Monthly Rates (per $1,000 of Life Insurance)
Under age 30	$0.05
Ages 30-34	$0.07
Ages 35-39	$0.09
Ages 40-44	$0.10
Ages 45-49	$0.15
Ages 50-54	$0.23
Ages 55-59	$0.43
Ages 60-64	$0.65
Ages 65-69	$1.22
Ages 70 +	$1.97

The monthly cost for children is $.11 per $1,000 of coverage. One premium will insure all your eligible children, regardless of the number of children you have.

VOLUNTARY VISION PLAN: ENROLLMENT ELECTION INFORMATION (Pre-Tax)

This is a voluntary plan separate from the vision coverage received if you enrolled in the Anthem medical plan. If you are not enrolled in medical, or if you are but wish to have a greater vision benefit, you can choose to enroll in this plan.

UniView Voluntary Vision Plan			
	Monthly	Bi-Weekly	COBRA
☐ Employee	$6.55	$3.28	$6.68
☐ Employee + One**	$12.46	$6.23	$12.71
☐ Employee + Family**	$18.29	$9.15	$18.66
I do not want to enroll in vision insurance coverage (Check here to decline vision) ☐			

ENROLLMENT TIP:
To locate an in-network vision care provider, call Unicare at 1-888-884-8428, or visit the Unicare website www.unicare.com, and use the *Find A Doctor* function.

Employees paid over less than 12 months will have a higher rate per pay period.

I have read and understand the explanation that I have received regarding my options under the Washington and Lee University Benefit Plan. I authorize the University to reduce my salary by the agreed upon amounts indicated on this form to pay premiums for myself and/or my dependents on a pre-tax basis for the Medical/Vision/Rx, Dental, Basic Life, Voluntary Vision and Flexible Spending Account coverage(s). I understand that due to provider and/or IRS regulations, my Medical, Dental, Basic Life, Voluntary Vision, and FSA coverage elections are binding until either my employer changes the plan or the duration of the plan year, whichever comes first. I acknowledge that my election cannot be changed during the current plan year that ends on **June 30, 2018** unless there is a change in my family status. A change in family status includes; marriage, divorce, death of a spouse or dependent, birth or adoption of a child, or a change in your employment status or that of your spouse. **I understand that I must report any change in family status (marriage, divorce, death, birth, adoption, loss of prior coverage) that may impact my insurance coverage to the Human Resources within 31 days of the event.** I also understand that my employee and employer contributions to Social Security will be somewhat reduced because some of my pay deductions are being taken on a pre-tax basis.

Please sign the applicable statement(s) below

Signature: _____ **Date:** _____