Benefits Enrollment / Change Form

☐ **New Hire Enrollment**

☐ **Open Enrollment**

Plan Year: ____________

☐ **Qualifying Event** Event Date ____________

Notice: Mid-year changes must be requested within 31 days of the qualifying event. Requests made after 31 days will need to be made during the next open enrollment period.

Reason: ☐ Marriage ☐ Adoption ☐ Birth ☐ Legal Guardianship ☐ Divorce

☐ Other: ____________

Employee Information

WKU ID	Last Name	First Name/MI	SSN

Address	City	State	Zip	Telephone

Annual Salary	Date of Hire	Date of Birth	Occupation	Sex	Marital Status
				☐ M ☐ F	☐ Single ☐ Married

Medical/Dental Benefit Options

Medical/Vision (Group #: 00070542)			Dental (Group #: 666530)
Blue Access ***High***	*Blue Access* ***Standard***	*Blue Access* ***Economy***	☐ ***Core*** ☐ ***Premier***
☐ Elect ☐ Waive ☐ Change	☐ Elect ☐ Waive ☐ Change	☐ Elect ☐ Waive ☐ Change	☐ Elect ☐ Waive ☐ Change

Medical/Vision:

- ☐ Employee Only (N/A on Economy)
- ☐ Emp + Child (ren)
- ☐ Emp + Spouse
- ☐ Family
- ☐ Cross Ref Family
- ☐ Cross Ref Couple
- ☐ Emp + OQD
- ☐ Emp + OQD + EE Child(ren)
- ☐ Emp + OQD + OQD Child(ren)
- ☐ Emp + OQD Child(ren)
- ☐ Emp + OQD + Family Mix
- ☐ Cross Reference Family (N/A Economy)
- ☐ Cross Ref Couple (N/A on Standard or Economy)

Name of WKU Employed Spouse/OQD for Cross Reference Options: ____________

Dental:

- ☐ Employee Only
- ☐ Emp + Child (ren)
- ☐ Emp + Spouse
- ☐ Family
- ☐ Emp + OQD
- ☐ Emp + OQD + EE Child(ren)
- ☐ Empl + OQD + OQD Child(ren)
- ☐ Empl + OQD Child(ren)
- ☐ Emp + OQD Family Mix

Dependent Information (Check all that apply)

Medical /Vision	Dental	Name	SSN	DOB	Sex M	Sex F	Relationship	Drop	Add
☐	☐				☐	☐		☐	☐
☐	☐				☐	☐		☐	☐
☐	☐				☐	☐		☐	☐
☐	☐				☐	☐		☐	☐
☐	☐				☐	☐		☐	☐

Life Insurance Options

Policy #: 40989	**Benefit Group or Class:** All Full Time Employees	Decline	Drop	Add	Coverage Amount Elected
Basic Life Insurance - The university provides a $30,000 term life policy at no cost to all full-time employees.				☑	$ 30,000
Optional Life - Employees may choose to purchase additional amounts of insurance up to $500,000 in multiples of $10,000 increments. (Please see your benefits representative for rate schedule.)		☐	☐	☐	
Dependent Life - Employees may select a $5,000 or $10,000 policy on all dependent children.		☐	☐	☐	
Spousal Life - Employees may choose to purchase spousal life insurance in multiples of $10,000 or an amount equal to one half of the employee optional coverage amount but not to exceed $80,000. (Please see your benefits representative for rate schedule.)		☐	☐	☐	

Spouse's Name (Last, Name, MI)	SSN	DOB	Date of Marriage

Names(s) of Child(ren) to be covered (attach additional pages if needed)	Date(s) of Birth

Life Insurance Beneficiary Information

Name	Address	SSN	Relationship	Beneficiary Designation (Must equal 100%)			
				Primary %	Contingent %	Basic Life	Optional Life
						☐	☐
						☐	☐
						☐	☐
						☐	☐

Disability Options

	WKU Paid	Decline	Drop	Add
Long-Term Disability Plan - The university provides Long-Term Disability at no cost for all full-time employees after a 90 day elimination period for qualified disabilities. The policy will pay 60% of monthly salary up to $5,000 monthly maximum.	☑			
Short-Term Disability - The university offers its employees the opportunity to purchase a Short-Term Disability policy through Sun Life which consists of 60% of weekly salary up to a maximum of $1,250 per week for a maximum benefit period of 13 weeks. Deductions are post-tax. (Please see your benefits representative for rate schedule.)		☐	☐	☐

Flexible Spending Reimbursement Account

I authorize a contribution to be made to my **Health Care Reimbursement Account** and/or my **Dependent Care Reimbursement Account:**

- The maximum contribution amount for my healthcare flexible spending account is $4,000 per year. This amount can be used to pay for eligible health, dental, and vision care for me and my dependents. The maximum contribution amount for my voluntary dependent care account is $5,000 per year. This can only be used for the care of eligible dependents, which include children under the age of 13 whom are claimed as dependents on my federal tax returns or any other dependent who is mentally or physically disabled and spend at least eight hours in my home each day.
- I understand that the amount(s) I elect will be deducted from my pay on a pre-tax basis in equal amounts throughout the course of the plan year based on my pay frequency.

Health Care Waiver Account	Health Care Voluntary Account	Dependent Care Voluntary Account
Do you elect to participate: ☐ Yes ☐ No	Do you elect to participate: ☐ Yes ☐ No	Do you elect to participate: ☐ Yes ☐ No
Reason for Waiving Coverage:	Annual Election Amount $	Annual Election Amount $

I hereby authorize Western Kentucky University to deduct from my earnings the appropriate amount or to make the necessary changes and/or adjustments as indicated on this form, with regard to my choices for group benefits, and to remit any deduction to the appropriate Insurance Company or Benefit Plan. All qualified premiums will be deducted on a pre-tax basis unless otherwise noted in writing to the Department of HR. I understand by my participation in these plans that:

- I may not change or stop my contribution during the plan year unless my family or employment status changes (i.e. marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, unpaid leave of absence, etc.). Such a change in my election must be the result of, and consistent with, the event causing the election change, and must qualify under the terms and conditions of the plan. All changes outside the open enrollment period must be submitted to Human Resources within 31 days of the qualifying event.
- In addition, I understand that the effective date for beneficiary changes made by me will be effective on the date I signed this form.
- IRS rules require that any amount not used for covered expenses under my Health Care or Dependent Care Reimbursement Account cannot be returned to me. I understand that I have until March 31 of each year to submit claims incurred during the prior year (January 1 through March 15). I also understand that any change made to my election as the result of a qualifying event cannot be used to cover expenses incurred prior to the qualifying event.
- In the event I do not elect STD or optional life insurance coverage(s) at the time of eligibility or if I elect and later decide to drop coverage, I understand that I will be required to furnish medical evidence of insurability at my own expense, and the insurance company will have the right to refuse my request for coverage.
- I have received and read all written materials provided to me describing the plans, and agree to the terms of participation set forth in the written materials.

Employee Signature ______________________ Date ______________________

For Human Resources Use Only

Date Received: ______________________

Date Processed: ______________________ **Processed By:** ______________________

Date Effective: ______________________