# WICHITA STATE UNIVERSITY
# INTERCOLLEGIATE ATHLETIC ASSOCIATION, INC.

Benefit Election Form - Plan year 01/01/24 – 12/31/24

Rates shown are per Pay Period

**PLEASE COMPLETE ALL OF THE FIELDS:**

| Name | Hire Date | WSU ID Number | Social Security Number |
|---|---|---|---|

| Address | City | State | Zip Code | Date of Birth |
|---|---|---|---|---|

## BCBS Medical + Dental

**You are currently enrolled in:**

**Please Select:** ☐ **No Changes** ☐ **Enroll** ☐ **Make a Change**

**A. If you are ENROLLING or MAKING A CHANGE, please select:**

| | Employee Only | Employee + Spouse | Employee + Children | Family | Premium Amount |
|---|---|---|---|---|---|
| **Option 1 - $1500 + Dental** | ☐ $82.37 | ☐ $281.28 | ☐ $262.04 | ☐ $452.33 | |
| **Option 2 - $5000 + Dental** | ☐ $47.80 | ☐ $206.96 | ☐ $192.00 | ☐ $342.54 | |

**B. If you are ADDING or REMOVING a Spouse and/or Dependent on your Medical, please complete below:**

| | | | | |
|---|---|---|---|---|
| ☐ **ADD** ☐ **REMOVE** | ☐ Male ☐ Female | **Spouse Name:** | Date of Birth: | Social Security Number: |
| ☐ **ADD** ☐ **REMOVE** | ☐ Male ☐ Female | **(1) Child Name:** | Date of Birth: | Social Security Number: |
| ☐ **ADD** ☐ **REMOVE** | ☐ Male ☐ Female | **(2) Child Name:** | Date of Birth: | Social Security Number: |
| ☐ **ADD** ☐ **REMOVE** | ☐ Male ☐ Female | **(3) Child Name:** | Date of Birth: | Social Security Number: |
| ☐ **ADD** ☐ **REMOVE** | ☐ Male ☐ Female | **(4) Child Name:** | Date of Birth: | Social Security Number: |

**C. To CANCEL COVERAGE, please select below:**

☐ **I wish to cancel medical & dental coverage effective 12/31/23**

**D. WAIVER OF MEDICAL INSURANCE:**

This is to certify that I have been given the opportunity to apply for Group Medical Coverage available to me through my employer and I have decided to waive coverage for the 2024 plan year because:

- ☐ I am covered by another group plan (spouse's plan, parent's plan or other employer plan)
- ☐ I am covered by an individual medical plan
- ☐ I am covered by Medicare
- ☐ Other: _____

By waiving your enrollment rights at this time, you understand that you cannot enroll in the group plan(s) unless you have a qualifying event or during your employer's open enrollment period.

| EMPLOYEE SIGNATURE | DATE |
|---|---|
| | |

## Surency Vision

**You are currently enrolled in:**

**Please Select:** ☐ No Changes ☐ Enroll ☐ Make a Change ☐ Terminate

| If Enrolling or Changing, please select: | Employee Only | Employee + Spouse | Employee + Children | Family | Premium Amount |
|---|---|---|---|---|---|
| Option 1 – Exam + Materials | ☐ $4.97 | ☐ $9.73 | ☐ $8.68 | ☐ $13.45 | |
| Option 2 – Materials Only | ☐ $4.87 | ☐ $9.54 | ☐ $8.51 | ☐ $13.18 | |

## 3in1 Supplemental Health Plan – Guardian

**You are currently enrolled in:**

**Please Select:** ☐ No Changes ☐ Enroll ☐ Make a Change ☐ Terminate

| If Enrolling or Changing, please select: | Employee Only | Employee + Spouse | Employee + Children | Family | Premium Amount |
|---|---|---|---|---|---|
| | ☐ $12.78 | ☐ $25.35 | ☐ $19.20 | ☐ $32.06 | |

## Voluntary Life Insurance Plan – Guardian

**Current Employee Coverage:** $

**Current Spouse Coverage:** $

**Current Child Coverage:** $

**Please Select:** ☐ No Changes ☐ Enroll ☐ Make a Change ☐ Terminate

**Employees may increase existing coverage by an amount up to $50,000, not to exceed the Guaranteed Issue Amount, without answering medical questions (EOI).**

**If Enrolling or Making a Change, write in coverage amounts below and complete a Guardian Beneficiary Form.**

| | | | |
|---|---|---|---|
| **2024 Coverage Amount:** | **Employee:** | **Spouse:** | **Dependent:** |
| **2024 Premium Amount:** | **Employee:** | **Spouse:** | **Dependent:** |

| Flexible Spending Accounts (FSA) | Employee Per Pay Period Election | Employee Annual Election |
|---|---|---|
| **Option 1: Medical Care**<br>Maximum Annual Contribution **$3,200.00** | | |
| **Option 2: Dependent Care**<br>Maximum Annual Contribution **$5,000.00** | | |

***IF YOU ARE PARTICIPATING IN AN FSA, MAKE SURE YOUR EMAIL IS LISTED ON THE 1ST PAGE!**

## SIGNATURE REQUIRED - Participant Authorization

By submitting this completed election form, I certify the information is accurate, understand the election is binding and cannot be changed during the plan year, except for a qualified status change. By completing, signing and submitting this form, I request my employer to make pre-tax deductions for eligible group insurance premiums.

| EMPLOYEE SIGNATURE | DATE |
|---|---|
| | |