Benefits Enrollment Form

WESLEYAN UNIVERSITY

Name: _____ **WES ID:** _____ **Effective Date:** _____

For a full description of Wesleyan University benefits and current year rates, please refer to the summary plan documents provided on the Human Resources website at www.wesleyan.edu/hr/, You have 30 days from the date of hire/effective date to enroll in the Wesleyan benefit plans. New faculty arriving for the new academic year has until September 30th to enroll.

Authorization

I have reviewed the benefits offered to me by Wesleyan University and understand that I have access to detailed plan information through the Human Resources Website. If there is a conflict or inconsistency between the summary and the plan itself, I understand that the plan documents will govern. I also understand that Wesleyan University reserves the right to modify, amend or terminate all or part of any of the plans at any time and to cancel all or part of the coverage and benefits under the plans, subject to the requirements associated with any applicable collective bargaining agreement. I hereby authorize Wesleyan University to deduct from my paycheck, the employee cost of the benefits I am electing.

_____ _____

Employee Signature **Date**

Health Plans

Medical:	☐ Waive ☐ CIGNA HMO ☐ CIGNA POS ☐ CIGNA HSA High Deductible	**Coverage:**	☐ Employee Only ☐ Employee Plus One ☐ Employee Plus Two + ☐ Employee Plus Domestic Partner ☐ Employee Plus One or More with Domestic Partner
Dental:	☐ Waive ☐ Delta	**Coverage:**	☐ Employee Only ☐ Employee Plus One ☐ Employee Plus Two + ☐ Employee Plus Domestic Partner ☐ Employee Plus One or More with Domestic Partner
Vision:	☐ Waive ☐ EyeMed	**Coverage:**	☐ Employee Only ☐ Employee Plus One ☐ Employee Plus Two + ☐ Employee Plus Domestic Partner ☐ Employee Plus One or More with Domestic Partner

Health Plan Dependents

	Name	Relationship	Social Security No.	Date of Birth	Coverage
☐ Add ☐ Remove					☐ Med ☐ Den ☐ Vis
☐ Add ☐ Remove					☐ Med ☐ Den ☐ Vis
☐ Add ☐ Remove					☐ Med ☐ Den ☐ Vis
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Flexible Spending Accounts

☐ **Medical Expenses Reimbursement Account (MERA):**

☐ Waive ☐ Elect Annual Contribution: $_____

☐ **Dependent Care Reimbursement Account:**

☐ Waive ☐ Elect Annual Contribution: $_____

Disability Insurance

Short Term Disability: University Provided **Long Term Disability: University Provided**

Life Insurance

**Please keep in mind life insurance benefits reduce starting at age 65.*

***Please contact HR for EOI forms to apply for additional coverage over the guaranteed limit.*

Basic Life: *University Provided – 1x Pay up to $50,000*

Supplemental Life: ☐ Waive ☐ 1x Pay ☐ 2x Pay ☐ 3x Pay ☐ 4x Pay ☐ 5x Pay **EOI required over $200,000
☐ Smoker ☐ Non-Smoker

Spouse/Domestic Partner Life: ☐ Waive ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000
☐ Smoker ☐ Non-Smoker ☐ $60,000 ☐ $70,000 ☐ $80,000 ☐ $90,000 ☐ $100,000 **EOI required over $30,000

Child Life: ☐ Waive ☐ Elect ($5,000 per child)

Beneficiary Designation

Beneficiary designation is required for basic life insurance, regardless of whether or not you select supplemental insurance.

Beneficiary 1:

Name	Relationship	Date of Birth	Social Security Number	
Address			**% Benefit**	
				☐ Primary ☐ Contingent

Beneficiary 2:

Name	Relationship	Date of Birth	Social Security Number	
Address			**% Benefit**	
				☐ Primary ☐ Contingent

Beneficiary 3:

Name	Relationship	Date of Birth	Social Security Number	
Address			**% Benefit**	
				☐ Primary ☐ Contingent

Beneficiary 4:

Name	Relationship	Date of Birth	Social Security Number	
Address			**% Benefit**	
				☐ Primary ☐ Contingent

Beneficiary 5:

Name	Relationship	Date of Birth	Social Security Number	
Address			**% Benefit**	
				☐ Primary ☐ Contingent