Wesleyan University

2024 Benefits Enrollment

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

Please Read: Use this form to elect your health insurance plans and designate life insurance beneficiary(ies). Once completed, upload the signed form to the secure benefits drop box - Upload

Authorization

I have reviewed Wesleyan University's health insurance plans 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 the plan documents will govern. I understand 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 select.

_____ _____

Employee Signature **Date**

Health Plans

Medical:
- ☐ Waive
- ☐ CIGNA Open Access Plus In-Network
- ☐ CIGNA Open Access Plus
- ☐ CIGNA High Deductible Plan

Tier Level:
- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Domestic Partner
- ☐ Family including Spouse/Domestic Partner

Select One

Dental Core:
- ☐ Waive
- ☐ Delta Dental of NJ/CT

Dental Buy Up:
- ☐ Waive
- ☐ Delta Dental of NJ/CT

Tier Level:
- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Domestic Partner
- ☐ Family including Spouse/Domestic Partner

Vision:
- ☐ Waive
- ☐ EyeMed

Tier Level:
- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Domestic Partner
- ☐ Family including Spouse/Domestic Partner

Dependents - Add/Remove

	Name	Relationship	M/F	Social Security No.	Date of Birth	Coverage
☐ Add ☐ Remove						☐ Med ☐ Den ☐ Vis
☐ Add ☐ Remove						☐ Med ☐ Den ☐ Vis
☐ Add ☐ Remove						☐ Med ☐ Den ☐ Vis
☐ Add ☐ Remove						☐ Med ☐ Den ☐ Vis
☐ Add ☐ Remove						☐ Med ☐ Den ☐ Vis
☐ Add ☐ Remove						☐ Med ☐ Den ☐ Vis

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Flexible Spending Accounts (FSA)/Health Savings Account (HSA)

☐ **Medical Expenses Reimbursement Account (MERA) Annual Plan Limit $3,200:**

☐ Waive ☐ Elect Annual Contribution: $_____

☐ **Dependent Care Reimbursement Account Annual Plan Limit $5,000:**

☐ Waive ☐ Elect Annual Contribution: $_____

☐ **Health Savings Account (HSA) Annual Plan Limit $4,150 - Employee (Maximum Election $3,650):**

☐ Waive ☐ Elect Annual Contribution: $_____

☐ **Health Savings Account (HSA) Annual Plan Limit $8,300 - Family (Maximum Election $7,300):**

☐ Waive ☐ Elect Annual Contribution: $_____

Disability Insurance

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

Life Insurance

Life insurance benefits are reduced starting at age 65.
**Contact Human Resource for EOI forms to apply for additional coverage over the life insurance guaranteed limit.

Basic Life: University Provided at No Cost to Employee - 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 ☐ $5,000 ☐ $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, up to age 26)

Beneficiary Designation

Beneficiary designation is required for basic life insurance, regardless of whether you select supplemental insurance.

Beneficiary 1:

Name	Relationship	Date of Birth	Destinate Percentage (%):
			☐ Primary _____% ☐ Contingent _____%
Address			
City/State/Zip Code			

Beneficiary 2:

Name	Relationship	Date of Birth	Destinate Percentage (%):
			☐ Primary _____% ☐ Contingent _____%
Address			
City/State/Zip Code			

Beneficiary 3:

Name	Relationship	Date of Birth	Destinate Percentage (%):
			☐ Primary _____% ☐ Contingent _____%
Address			
City/State/Zip Code			