Employee Benefits Summary Enrollment Form -- 2014

Name _____ M# _____ Campus Phone _____
(Last) (First) (MI)

Department _____ E-Mail _____

- **Complete all eight (8) sections listed below, sign, and return to Human Resources, 412 Sparks Hall; Fax 809-3464**
- **If adding or dropping dependents, or changing coverage, please complete the appropriate enrollment forms.**

1. HEALTH INSURANCE – Complete Anthem Blue Cross & Blue Shield Membership Application if changing coverage.

☐ Yes - I wish to continue my 2013 Health insurance choice for 2014. (No change in coverage and/or dependents.)
☐ I wish to add or change my Health insurance coverage to: (Attach Completed Health application for any changes.)

Monthly Employee Costs	*HDHP (C)	**Blue Access Standard PPO (A)	**Blue Access Enhanced PPO (B)	Opt Out (Waiving Health Coverage)
Employee Only	☐ $ 0	☐ $ 30.60	☐ $104.20	
Employee+Child(ren)	☐ $15.80	☐ $106.40	☐ $228.60	☐ Opt out of MSU's health insurance
Employee+Spouse	☐ $19.30	☐ $120.00	☐ $255.80	Covered by:
Employee+Spouse+Child(ren)	☐ $63.40	☐ $212.70	☐ $416.40	☐ Spouse's insurance
Extended Family (Partner)	☐ $368.29	☐ $419.60	☐ $478.02	☐ Other _____
Extended Family [Partner+Child(ren)]	☐ $739.12	☐ $841.23	☐ $951.97	

2. DENTAL INSURANCE

☐ Yes - I wish to continue my 2013 Dental insurance choice for 2014.
☐ I wish to add or change my Dental insurance coverage to: (Attach Completed Dental Form for any changes.)

	Standard	Enhanced
Employee (EE) Only	☐ $18.43	☐ $31.31
EE + EE's Family	☐ $54.95	☐ $81.87
EE + EE's Extended Family [(Partner and/or Child(ren)]	☐ $54.95	☐ $81.87

☐ Opt Out (Waiving Dental Coverage)

3. VISION INSURANCE

☐ Yes - I wish to continue my 2013 Voluntary Vision insurance for 2014.
☐ I wish to add or change my Voluntary Vision insurance to: (Attach Completed Vision Form for any changes)

☐ $ 7.58 Employee (EE) Only
☐ $13.99 EE + Child(ren)
☐ $14.85 EE + Spouse
☐ $21.26 EE + EE's Family
☐ $14.85 EE + Extended Family (Partner)
☐ $21.26 EE + Extended Family [Partner+Child(ren)]

☐ Opt Out (Waiving Vision Coverage)

4. *HEALTH SAVINGS ACCOUNT (Must have HDHP to have HSA)

I wish to participate in the HSA in 2014.
☐ Yes - (Attach Completed HSA Enrollment Form)
(BenefitWallet Info. Will be Mailed 1st yr.)
☐ No

Minimum Per Pay: Bi-weekly $5.50; Annually $132
Minimum Per Pay: Monthly $11; Annually $132
Maximum Per Year: Single $3,300; Family $6,550
(Add $1,000 to Maximum if Age 55 or Older)

$_____ **Annual** Contribution

5. **HEALTH CARE FLEXIBLE SPENDING ACCOUNT

I wish to participate in 2014. (Cannot have HDHP Health Coverage to Enroll in Medical FSA)
☐ Yes - (Attach Completed WageWorks Enrollment Form)
☐ No

Minimum $50; maximum $2,500

$_____ **Annual** Contribution

6. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT – (Day Care)

I wish to participate in 2014.
☐ Yes - (Attach Completed WageWorks Enrollment Form)
☐ No

Minimum $50; Maximum $5,000 for married couple filing jointly or single parent filing "Head of Household"

$_____ **Annual** Contribution

7. LIFE INSURANCE (EFFECTIVE 7/1/13 NEW COMPANY – SUN LIFE ASSURANCE CO. OF CANADA)

☐ NOTE: **Everyone must complete a new life insurance application.** (Attach completed Life & AD&D Insurance & Supplemental Coverage Form.)
☐ Yes – I wish to purchase supplemental life insurance in increments of $10,000 @ cost of $.24/$1,000 up to $250,000 without EOI. Can purchase over $250,000 up to $500,000 with EOI. (Add supplemental amount to completed Life Insurance Form.)

8. SICK LEAVE BANK – Balance of six (6) sick days required to initially participate.

☐ Yes – I am a current member of the sick leave bank and wish to continue for 2014. No contribution required.
☐ Yes – I am not a member of the sick leave bank and wish to join for 2014. A contribution of (1) day is required.
☐ No – I do not wish to be a member of the sick leave bank in 2014.

AUTHORIZATION

I hereby authorize Murray State University to deduct from my pay my share of the costs, if any, of the benefits I have selected above. Furthermore, I understand that I cannot make changes until the next open enrollment period unless I have a change in family status, in which case **forms must be signed and changes must be made in Human Resources within 30 days of the event date.** I understand that my sick leave bank donation is irrevocable and I cannot assign the donation to any specific individual. I certify that the information provided above is true and accurate to the best of my knowledge.

I may obtain a copy of the HIPAA Privacy Notice for the MSU Employee Health Plan (Anthem Blue Cross/Blue Shield) and the MSU Health Care Flexible Spending Account (WageWorks Corporation) by contacting the MSU Human Resources Department, 412 Sparks Hall, 809-2146.

Signature _____ Date _____