Washington University in St. Louis

Bargaining Unit Employees 2017 Enrollment/Change Form

Submit completed form to:

Medical School Benefits- Campus Box 8002/Fax (314) 362-2500
Danforth Benefits- Campus Box 1190/Fax (314) 935-8198

SEE BACK OF FORM FOR INSTRUCTIONS

(A) PERSONAL INFORMATION

Employee ID - **Required**	Last Name	First Name	MI

B) ENROLLMENT/CHANGE *Enrollments/changes are effective the first of the month following the date of event*

Reason For Enrollment/Change: ❑ **New Hire** ❑ **Family Status Change (check one)** Date of Event___________

❑ Birth or Adoption*	❑ Dependent No Longer Eligible	❑ Marriage
❑ Change of Employment Status	❑ Divorce/Legal Separation**†	❑ Spouse's Open Enrollment
❑ Death	❑ Loss of other coverage	❑ Termination/Commencement of Employment

(C) HEALTH INSURANCE (Skip Section E if not enrolling in High Deductible Health Plan)

I Elect To:	***Plan Type: (UHC Networks)***	***Coverage Level:***
❑ Enroll in Health/Dental	❑ HMO/EPO	❑ Individual Only
❑ Enroll in Advantica Dental Only	❑ POS	❑ Individual + Child/ren
❑ Change Plan or Coverage	❑ Excel PPO	❑ Individual + Spouse/Partner
❑ Waive Health/Dental Coverage	❑ Basic PPO	❑ Family

(D) DEPENDENT INFORMATION *(List covered dependents only. If enrolling more than four children, please complete an additional form.)*

Action	Relationship	Date of Birth	Name Last (if different), First, MI	Gender	Is Dependent Disabled?
❑ Add ❑ Delete	❑ Spouse ❑ Domestic Partner	___/___/___	**NAME** **SSN**	❑ Male ❑ Female	❑ Yes ❑ No
❑ Add ❑ Delete	Child-1	___/___/___	**NAME** **SSN**	❑ Male ❑ Female	❑ Yes ❑ No
❑ Add ❑ Delete	Child-2	___/___/___	**NAME** **SSN**	❑ Male ❑ Female	❑ Yes ❑ No

(E) HEALTHCARE FLEX SPENDING ACCOUNT (FSA) (Not available to employees enrolled in HSA)

I Elect To:
❑ Enroll in 2017 Healthcare FSA

Annual Contribution Amount $___________
Contributions divided by applicable number of pay periods. Max contribution $2,550 per employee.

(F) CHILDCARE FLEX SPENDING ACCOUNT (FSA)

I Elect to:
❑ Enroll in the 2017 Childcare FSA

Annual Contribution Amount $_____________

If married, does spouse earn over $5,000 a year **or** is a full-time student?
☐ Yes ☐ No If no, please state spouse's annual income $__________
(Max Contribution $5,000 per household)

(G) AUTHORIZATION

My signature below indicates that I have received, read and understand the materials describing the options available to me. I hereby certify that all the information provided is true and correct to the best of my knowledge. I realize that I am making a binding election for the coming calendar year, which can only be changed if I experience a family status change. I hereby authorize Washington University to deduct the contribution amounts and/or premiums directly from my paycheck.

SIGNATURE: **DATE:**

HR OFFICE USE ONLY	Entered by	Date Entered	Effective Date

Washington University
Benefits Enrollment/Change Instructions
See the Benefits Summary for plan details or visit our website at http://hr.wustl.edu

A) PERSONAL INFORMATION and (B) ENROLLMENT/CHANGE

Please print legibly and complete all information. Check new hire or status change box. If rehired, check new hire box. Enter date of hire or date of status change. For status changes, choose appropriate change from the list. Forms must be received w/in 31 days of hire, rehire or status change (62 days for birth or adoption- healthcare only).

*Include a copy of adoption papers with date of custody.

**Include a copy of page of decree with date of divorce, name, SSN and address of ex-spouse

†Ending your relationship with a domestic partner is a qualifying event to remove the individual from your health/dental plan. However, should you renew your relationship with the same partner, you must wait until the next open enrollment to re-enroll him/her as a covered dependent.

(C) HEALTH INSURANCE

Choose election, plan type, and coverage level. Premiums are withheld pre-tax, although special tax rules apply for domestic partners. Enrollment in health automatically includes enrollment in Advantica Dental plan. If enrolling in "Advantica Dental Only" skip *Plan Type*. If enrolled under spouse's coverage at the University check waive box. By waiving health and dental coverage employee acknowledges changes may be made only in the event of a family status change or during open enrollment.

(D) DEPENDENT INFORMATION

Complete section D only if you are adding or deleting dependents from health/dental coverage. A Health/Dental Plan Dependent Verification Affidavit is required from all employees covering dependents and should accompany this form. *When adding a Domestic Partner, you must also complete a *Domestic Partner Verification Form* (available on the HR website at http://hr.med.wustl.edu or http://hr.wustl.edu) and provide proof of residency with your enrollment form.

Eligible dependents are a spouse or a domestic partner who resides with you, a child or a disabled child. Definition of Child- age birth to 26 who is your birth, adopted, step child, child of a domestic partner, child placed with you for adoption or a child for whom you have full legal guardianship. A child for whom healthcare coverage is required under a Qualified Medical Child Support Order or court order also qualifies. Children (as outlined above) who are 26 years of age or older and are incapable of self-support because of mental or physical disability are also eligible for coverage, provided that the disability existed prior to the child reaching age 26 and the child was covered as a dependent under a University health plan immediately prior to reaching age 26.

The university reserves the right to periodically request proof of eligibility.

(E) HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Contribution is withheld pre-tax for the 2017 calendar year. Minimum annual contribution is $120. Maximum annual contribution is $2,550 *per employee*. If enrolling in FSA, you may not enroll in the HSA.

(F) CHILDCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Contribution is withheld pre-tax for the 2017 calendar year. Minimum annual contribution is $120. Maximum contribution is $5,000 *per household* or the lesser of you or your spouse's income. Spouse must work or be a full-time student.

(G) AUTHORIZATION

Please sign and date form. Unsigned forms will be returned to employee unprocessed. **Submit completed forms to: Medical School Benefits- Campus Box 8002 or fax to (314) 362-2500. Danforth Benefits- Campus Box 1190 or fax to (314) 935-8198.**