The Mississippi University for Women
Founded 1884 Coeducational since 1982

HUMAN RESOURCES

Benefits Election Form

Use this form to indicate the benefits you wish to elect. Some benefits require you to complete a paper form. If this is required, the forms are included in your employment packet and must be filled out in completion, even if you have provided the information on this form.

1. Employee Information

Benefits Effective: _____/_____/_____

Name (Last, First, MI)	**Date of Birth (mm/dd/yyyy)**	**Social Security Number**

Home Address	**City, State, ZIP**

Personal Email Address	**Phone**	**Hire Date**

Marital Status	**Gender (M/F)**	**Hours Per Week:**	**Annual Salary**
☐ Single ☐ Married		☐ FT or ☐ PT _____	

Title	**MUW ID#**

Select One: ☐ Initial/New Hire ☐ Status Change (Add or Drop Dependents) ☐ Drop/Refuse Coverage

STOP

You MUST complete a separate form for the State and School Employees' Health and/or Life Insurance, whether you elect or waive coverage. You must also sign the acknowledgement on page 6.

Complete this form to elect OR waive the following benefits.

♦ Guardian Dental, Vision, Life or Accident ♦ Reliance Standard Disability or Life ♦ Kemper Cancer or Critical Illness ♦ Unreimbursed Medical Spending ♦ Dependent Care Spending

2. Persons To Be Enrolled/Dependent Information

Only complete this section if you are enrolling spouse and/or dependents. Employee must be enrolled to cover dependents, where applicable. Include the names of the all dependents you wish to enroll in coverage (other than State Health). Additional information may be required for non-standard dependents.

Last Name	First Name	Social Security Number	Relationship	Gender (M/F)	D.O.B. (mm/dd/yyyy)

Employee Name: _____

3. Guardian Dental (Pre-tax)

Check only one box to enroll or select to waive coverage.			
☐ Employee Only $45.90 monthly premium	☐ EE & Spouse $87.96 monthly premium	☐ EE & Dependent/Child(ren) $108.96 monthly premium	☐ EE, Spouse & Dependent/Child(ren) $153.85 monthly premium
☐ Waive Coverage			

4. Guardian Vision (Davis) (Pre-tax)

Check only one box to enroll or select to waive coverage.			
☐ Employee Only $10.11 monthly premium	☐ EE & Spouse $15.73 monthly premium	☐ EE & Dependent/Child(ren) $16.30 monthly premium	☐ EE, Spouse & Dependent/Child(ren) $23.60 monthly premium
☐ Waive Coverage			

5. Guardian Life Insurance (Post-tax)

Check coverage options or select to waive coverage. Employee must enroll in this coverage to enroll spouse and/or dependent/child(ren). This benefit requires you to complete beneficiary information on page 5. Evidence of Insurability is required if the elected amount exceeds the Guarantee Issue.		
☐ Employee Only Policy Amount $_____ Monthly Premium $_____	☐ Add Spouse Coverage Policy Amount (not more than 50% of EE amount) $_____ Monthly Premium $_____	☐ Add Dependent/Child(ren) Coverage Policy Amount (not more than 10% of EE amount) $_____ Monthly Premium $_____
☐ Waive Coverage	☐ I Do Not Want	☐ I Do Not Want
Total <u>Guardian Life Insurance</u> Premium $ _____		

Employee Name: _____

6. Guardian Accident (Pre-tax)

Check only one box to enroll or select to waive coverage. This benefit requires you to complete beneficiary information on page 5			
☐ Employee Only $13.28 monthly premium	☐ EE & Spouse $21.56 monthly premium	☐ EE & Dependent/Child(ren) $21.65 monthly premium	☐ Family $29.93 monthly premium
☐ Waive Coverage			

7. Reliance Standard Disability (Post-tax)

Employee Only Coverage ***Check only one box to enroll or select to waive coverage.***				
☐ Option 1 0/3 day EP Benefit Amount $_____ Monthly Premium $_____	☐ Option 2 14 day EP Benefit Amount $_____ Monthly Premium $_____	☐ Option 3 30 day EP Benefit Amount $_____ Monthly Premium $_____	☐ Option 4 90 day EP Benefit Amount $_____ Monthly Premium $_____	☐ Option 5 180 day EP Benefit Amount $_____ Monthly Premium $_____
☐ Waive Coverage				

8. Reliance Standard Life Insurance (Post-tax)

Check coverage options or select to waive coverage. Employee must enroll in this coverage to enroll spouse and/or dependent/child(ren). This benefit requires you to complete beneficiary information on page 5.				
Employee Coverage **Age** ☐ <39 ☐ 40+	**$20K** ☐ $4.20 ☐ $6.80	**$30K** ☐ $6.30 ☐ $10.20	**$50K** ☐ $10.50 ☐ $17.00	**$100K** ☐ $21.00 ☐ $34.00
☐ Waive Coverage				
Add Spouse Coverage **Age** ☐ <39 ☐ 40+	**$10K** ☐ $2.10 ☐ $3.40	**$20K** ☐ $4.20 ☐ $6.80	**$30K** ☐ $6.30 ☐ $10.20	**$40K** ☐ $8.40 ☐ $13.60
☐ I Do Not Want				
Add Children **$10K** for ☐ $2.60	☐ I Do Not Want			
Total Reliance Standard Life Insurance Premium $ _____				

Employee Name: _____

9. Kemper Health Critical Illness (Post-tax)

Check only one box to enroll or select to waive coverage. This benefit requires you to complete beneficiary information on page 5.			
NON-TOBACCO, Employee Age _____			
☐ Employee Only Benefit Amount $_____ Monthly Premium $_____	☐ EE & Spouse Benefit Amount $_____ Monthly Premium $_____	☐ EE & Dependent/Child(ren) Benefit Amount $_____ Monthly Premium $_____	☐ Family Benefit Amount $_____ Monthly Premium $_____
TOBACCO, Employee Age _____			
☐ Employee Only Benefit Amount $_____ Monthly Premium $_____	☐ EE & Spouse Benefit Amount $_____ Monthly Premium $_____	☐ EE & Dependent/Child(ren) Benefit Amount $_____ Monthly Premium $_____	☐ Family Benefit Amount $_____ Monthly Premium $_____
☐ Waive Coverage	☐ I Do Not Want	☐ I Do Not Want	☐ I Do Not Want

10. Kemper Health Cancer (Pre-tax)

Check only one box to enroll or select to waive coverage.			
☐ Employee Only ☐ Low $35.04 ☐ Mid $41.47 ☐ High $52.31	☐ EE & Spouse ☐ Low $68.54 ☐ Mid $81.16 ☐ High $102.11	☐ EE & Dependent/Child(ren) ☐ Low $40.14 ☐ Mid $47.26 ☐ High $59.27	☐ Employee & Family ☐ Low $71.43 ☐ Mid $84.48 ☐ High $106.19
☐ Waive Coverage	☐ I Do Not Want	☐ I Do Not Want	☐ I Do Not Want

Employee Name: _____

11. Flexible Spending Accounts (Pre-tax)

Check coverage options to enroll or select to waive coverage.	
☐ Unreimbursed Medical Expenses Annual Limit: $3, 050 (2023) Monthly Amount $_____	☐ Dependent Care Expenses Annual Limit: $5,000 Monthly Amount $_____
☐ Waive Coverage	☐ Waive Coverage

12. Beneficiary Information for Guardian Life, Guardian Accident and/or Reliance Standard Life

Primary Beneficiaries

If more than one, percentages must total 100%. If additional space is needed, attach a separate sheet of paper which includes all of the following information. Be sure to sign and date the additional sheet.

Name (Beneficiary 1)	**Social Security Number**	**Percentage**	**Benefit**
			☐ Guardian Accident ☐ Guardian Life ☐ Reliance Standard
Address/City/State/Zip	**Date of Birth (mm/dd/yyyy)**	**Relationship**	**Phone**
Name (Beneficiary 2)	**Social Security Number**	**Percentage**	**Benefit**
			☐ Guardian Accident ☐ Guardian Life ☐ Reliance Standard
Address/City/State/Zip	**Date of Birth (mm/dd/yyyy)**	**Relationship**	**Phone**
Name (Contingent Beneficiary)	**Social Security Number**	**Percentage**	**Benefit**
		N/A	☐ Guardian Accident ☐ Guardian Life ☐ Reliance Standard
Address/City/State/Zip	**Date of Birth (mm/dd/yyyy)**	**Relationship**	**Phone**

Employee Name: _____

13. Health History for Guardian Life and/or Reliance Standard Life

In the last 6 months have you or any or your dependents (only answer for spouse and dependents if electing this coverage) received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to Acquired Immune Deficiency Disorder (AIDS); or any other Chronic Condition?

☐ Yes, I have. ☐ No, I haven't. ☐ Yes, my spouse has. ☐ No, my spouse hasn't.

☐ Yes, my dependent child(ren) have. ☐ No, my dependent child(ren) haven't.

An Evidence of Insurability form must be completed for any person with a "Yes" answer.

14. State & School Employees' Health and/or Life Insurance (Pre-tax) Acknowledgement

State Health Insurance Election: ☐ Enroll ☐ Waive Premium Amount $_____ (for HR)

State Life Insurance Election: ☐ Enroll ☐ Waive Premium Amount $_____ (for HR)

This benefit requires that you complete a separate form, whether you elect or waive coverage.

If enrolling in health and/or life insurance, you agree to the terms as stated in section 15 below as acknowledged by your signature.

15. Employee Confirmation and Acknowledgement

- I hereby apply for myself and any dependents listed on this Election Form for the coverage indicated.
- If accepted, I understand that coverage is subject to the exclusions and all other provisions contained in the benefit plan.
- I understand that my salary will be reduced by the amount(s) shown for the benefit(s) I have elected as indicated by pre-tax or post-tax.
- I have carefully read this Election Form and understand it is the employee responsibility to read and understand the benefit(s) elected.
- I understand after the initial enrollment period of 30 days from date of hire, the Internal Revenue Code regulations only allow you to cancel or change your pre-tax coverage elections during the Open Enrollment period, unless you experience a qualified family status change as defined under the Code. Your benefit change must be consistent with your status change. You have 60 days to make corresponding changes; however, there could be payroll implications if you wait the full 60 days. Contact Human Resources as soon as possible to complete all applicable forms.

Employee Signature_____ Date_____