WICHITA STATE UNIVERSITY
INTERCOLLEGIATE ATHLETIC ASSOCIATION, INC.

Benefit Election Form - Plan year 01/01/25 – 12/31/25

Rates shown are per Pay Period

PLEASE COMPLETE ALL OF THE FIELDS:

Name	Hire Date	WSU ID Number	Social Security Number

Address	City	State	Zip Code	Date of Birth

BCBS Medical + Dental

You are currently enrolled in:

Please Select: ☐ **No Changes** ☐ **Enroll** ☐ **Make a Change**

A. If you are ENROLLING or MAKING A CHANGE, please select:

	Employee Only	Employee + Spouse	Employee + Children	Family	Premium Amount
Option 1 - $1500 + Dental	☐ $82.37	☐ $281.28	☐ $262.04	☐ $452.33	
Option 2 - $5000 + Dental	☐ $47.80	☐ $206.96	☐ $192.00	☐ $342.54	

B. If you are ADDING or REMOVING a Spouse and/or Dependent on your Medical, please complete below:

☐ **ADD** ☐ **REMOVE**	☐ Male ☐ Female	**Spouse Name:**	Date of Birth:	Social Security Number:
☐ **ADD** ☐ **REMOVE**	☐ Male ☐ Female	**(1) Child Name:**	Date of Birth:	Social Security Number:
☐ **ADD** ☐ **REMOVE**	☐ Male ☐ Female	**(2) Child Name:**	Date of Birth:	Social Security Number:
☐ **ADD** ☐ **REMOVE**	☐ Male ☐ Female	**(3) Child Name:**	Date of Birth:	Social Security Number:
☐ **ADD** ☐ **REMOVE**	☐ Male ☐ Female	**(4) Child Name:**	Date of Birth:	Social Security Number:

C. To CANCEL COVERAGE, please select below:

☐ **I wish to cancel medical & dental coverage effective 12/31/23**

D. WAIVER OF MEDICAL INSURANCE:

This is to certify that I have been given the opportunity to apply for Group Medical Coverage available to me through my employer and I have decided to waive coverage for the 2024 plan year because:

- ☐ I am covered by another group plan (spouse's plan, parent's plan or other employer plan)
- ☐ I am covered by an individual medical plan
- ☐ I am covered by Medicare
- ☐ Other: _____

By waiving your enrollment rights at this time, you understand that you cannot enroll in the group plan(s) unless you have a qualifying event or during your employer's open enrollment period.

EMPLOYEE SIGNATURE	DATE

Surency Vision

You are currently enrolled in:

Please Select: ☐ No Changes ☐ Enroll ☐ Make a Change ☐ Terminate

If Enrolling or Changing, please select:	Employee Only	Employee + Spouse	Employee + Children	Family	Premium Amount
Option 1 – Exam + Materials	☐ $4.97	☐ $9.73	☐ $8.68	☐ $13.45	
Option 2 – Materials Only	☐ $4.87	☐ $9.54	☐ $8.51	☐ $13.18	

3in1 Supplemental Health Plan – Guardian

You are currently enrolled in:

Please Select: ☐ No Changes ☐ Enroll ☐ Make a Change ☐ Terminate

If Enrolling or Changing, please select:	Employee Only	Employee + Spouse	Employee + Children	Family	Premium Amount
	☐ $12.78	☐ $25.35	☐ $19.20	☐ $32.06	

If you are Enrolling, Terminating, or Making a Change, you will need an additional form.

Voluntary Life Insurance Plan – Guardian

Current Employee Coverage: $

Current Spouse Coverage: $

Current Child Coverage: $

Please Select: ☐ No Changes ☐ Enroll ☐ Make a Change ☐ Terminate

Employees may increase existing coverage by an amount up to $50,000, not to exceed the Guaranteed Issue Amount, without answering medical questions (EOI).

If Enrolling or Making a Change, write in coverage amounts below and complete a Guardian Form.

2024 Coverage Amount:	**Employee:**	**Spouse:**	**Dependent:**
2024 Premium Amount:	**Employee:**	**Spouse:**	**Dependent:**

Flexible Spending Accounts (FSA)	Employee Per Pay Period Election	Employee Annual Election
Option 1: Medical Care Maximum Annual Contribution **$3,200.00**		
Option 2: Dependent Care Maximum Annual Contribution **$5,000.00**		

***IF YOU ARE PARTICIPATING IN AN FSA, MAKE SURE YOUR EMAIL IS LISTED ON THE 1ST PAGE!**

SIGNATURE REQUIRED - Participant Authorization

By submitting this completed election form, I certify the information is accurate, understand the election is binding and cannot be changed during the plan year, except for a qualified status change. By completing, signing and submitting this form, I request my employer to make pre-tax deductions for eligible group insurance premiums.

EMPLOYEE SIGNATURE	DATE