WAKE FOREST UNIVERSITY

Human Resources

Affordable Care Act Benefit Enrollment Form

Wake Forest University

The Affordable Care Act (ACA) requires Wake Forest to offer medical coverage that is both affordable and meets minimum essential value to employees who average 30 or more hours of service per week, or 130 or more hours per month either: (1) from the date of hire, as determined by Wake Forest based on the position; (2) after a change in employment status; or (3) as a variable hour, part-time, or seasonal employee during an applicable prior measurement period. Wake Forest's Value Medical Plan for employee only meets the ACA affordable and minimum essential value requirements.

This form is to be used by an employee that has met the ACA definition of full-time employment to elect medical coverage for oneself, and a spouse, and/or dependent children at the full-time benefit rates. ACA's definition of full-time employment only applies to medical coverage eligibility and does not impact your current employment status or eligibility for other benefits that are offered by the University (i.e. paid time off). If you are a working Retiree, please contact Benefit Advocates at 336-758-6233 to find out about any potential penalties you may incur if you choose to elect ACA medical coverage and decline Medicare coverage.

Even if you decide to waive coverage, complete and submit this form to Human Resources within 5 business day of your eligibility notification.

Personal Information

Name: _____ WFU ID: _____ Phone Number: _____

Spousal Surcharge

A $75 monthly ($34.62 biweekly) premium will apply to your payroll deduction if your spouse has access to medical coverage through an outside employer and you enroll him/her in the Wake Forest medical plan. Additional details are available on the Human Resources website. Please indicate the appropriate status for your medical election below.

☐ I am not covering my spouse on the Wake Forest medical plan (surcharge is waived).

Select Status:

☐ I am covering my spouse on the Wake Forest medical plan, but she/he/they does not have access to employer medical coverage ; she/he/they does not work; she/he/they is self-employed; she/he/they is employed at Wake Forest University (surcharge is waived).

☐ I am covering my spouse on the Wake Forest medical plan, and she/he/they has access to medical coverage through his/her employer (surcharge will apply).

Medical Plan

☐ New Coverage
☐ Change Coverage
☐ Cancel Coverage
☐ Waive

Select Coverage:

Value Plan	Core Plan
☐ **Employee Only** BW ($41.00); MO ($89.00)	☐ **Employee Only** BW ($76.00); MO ($165.00)
☐ **Emp. & Spouse** BW ($119.00); MO ($258.00)	☐ **Emp. & Spouse** BW ($204.00); MO ($442.00)
☐ **Emp. & Child** BW ($78.00); MO ($169.00)	☐ **Emp. & Child** BW ($133.00); MO ($288.00)
☐ **Emp. & Children** BW ($104.00); MO ($225.00)	☐ **Emp. & Children** BW ($178.00); MO ($358.00)
☐ **Family** BW ($150.00); MO ($326.00)	☐ **Family** BW ($258.00); MO ($558.00)

Dependent Information

Submit the required dependent verification documentation if you are adding a spouse and/or dependent child(ren) to your medical plan and have not previously submitted documentation. You may submit this documentation to Human Resources by emailing AskHR@wfu.edu, faxing to 336-758-6127, or sending through campus mail. Redact all personal and financial information (i.e. Social Security numbers or salary details) from these documents.

Name: Last, First, Middle Initial	SSN	Relationship	Date of Birth	Gender	Medical
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Wake Forest University is committed to fostering an inclusive environment that supports the gender identities of faculty, staff, and their families. The University also recognizes that information about biological sex is required by benefit providers before participants may enroll for coverage.

Reason for Completing Form

☐ Newly Eligible ☐ Marriage ☐ Divorce/Legal Separation ☐ Birth/Adoption of Child ☐ Employment/Benefit Change

Qualifying Event

Faculty and Staff have 30 days from the qualifying event date to add or remove a dependent or spouse from coverage. Supporting documentation is required. If dropping a dependent or spouse, any potential reimbursement will be forfeited if submitted after 30 days from the event.

Date of Event:

Pre-Tax Premium Plan

By signing below, I elect to have premiums for my medical and medical surcharge deducted from my pay on a pre-tax basis. Premiums will be deducted from my regular compensation on a pre-tax basis and will continue unless I elect otherwise. I understand that this election cannot be modified or terminated unless there is a change in family status or spouse's employment.

Important Information (read before signing)

I request the coverages for myself and any eligible dependents as listed on this form and authorize my employer to deduct from my pay my contribution (if any) to the cost of the coverages. For purposes of administration, eligibility, benefits, risk classification, fraud or misrepresentation, and audits, I authorize the above carriers, and their legal representatives and reinsurers, to release or obtain necessary medical records or claim information from any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility or insurance company. I give the carriers, their legal representatives, and any person or organization administering claims on behalf of the University permission to release to my employer or group policyholder a summary of claims incurred by my eligible dependents or me. This authorization is valid for a period of 30 months. I understand that my authorized representative or may receive a copy upon request. The summary of claims may be provided without identifying by name the person with his/her claim. The summary may include the nature of the condition, the date and nature of services rendered, the provider of the services, and the amount of the claim. I understand and agree that with the exception of medical emergency procedures, all medical plan services, in order to be covered at the highest benefit level, must be performed by either a participating provider or authorized by prior written referral. I will pay any required co-payments directly to the provider of health care. I agree to be bound by all terms of the plans under which I am applying for coverage. I agree that a copy of this authorization shall be valid as the original. I certify that, to the best of my knowledge, the information shown on this enrollment form is correct and that will notify the University and the carriers promptly of any changes to the information contained in this application.

Signature: Date:

Initials:_____ Date: _____ Payroll Effective Date: _____ Coverage Date: _____ Cobra:_____