WAKE FOREST UNIVERSITY

Human Resources

Benefits Enrollment Form

P.O. Box 7424 Winston Salem, NC 27109
Phone: 336.758.4700
Fax: 336.758.6127
Email: AskHR@wfu.edu

Personal Information

Name (Last, First, Middle Initial): _____ Pay Period: ☐ Monthly ☐ Biweekly

WFU ID: _____ Date of Hire: _____ Department: _____ 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.

Select status:

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

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

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

Medical Plan

☐ New Coverage
☐ Change of Existing Coverage
☐ Cancel Coverage
☐ No Change to Coverage
☐ Waive

Select coverage:

☐ Employee Only (Value)
☐ Employee & Spouse (Value)
☐ Employee & Child (Value)
☐ Employee & Children (Value)
☐ Family (Value)

☐ Employee Only (Core)
☐ Employee & Spouse (Core)
☐ Employee & Child (Core)
☐ Employee & Children (Core)
☐ Family (Core)

Dental Plan

☐ New Coverage
☐ Change of Existing Coverage
☐ Cancel Coverage
☐ No Change to Coverage
☐ Waive

Select coverage:

☐ Employee Only (Low)
☐ Employee & Spouse (Low)
☐ Employee & Child (Low)
☐ Employee & Children (Low)
☐ Family (Low)

☐ Employee Only (High)
☐ Employee & Spouse (High)
☐ Employee & Child (High)
☐ Employee & Children (High)
☐ Family (High)

Vision Plan

☐ New Coverage
☐ Change of Existing Coverage
☐ Cancel Coverage
☐ No Change to Coverage
☐ Waive

Select coverage:

☐ Employee Only
☐ Employee & Child
☐ Employee & Spouse
☐ Family

Dependent Information

Name: Last, First, Middle Initial	SSN	Relationship	Date of Birth	Gender	Medical	Dental	Vision
					☐Y ☐N	☐Y ☐N	☐Y ☐N
					☐Y ☐N	☐Y ☐N	☐Y ☐N
					☐Y ☐N	☐Y ☐N	☐Y ☐N
					☐Y ☐N	☐Y ☐N	☐Y ☐N
					☐Y ☐N	☐Y ☐N	☐Y ☐N
					☐Y ☐N	☐Y ☐N	☐Y ☐N

Flexible Spending Account

Flexible Spending Accounts must be re-elected every year. If you do not submit this form or enroll on-line, your FSA account will be termed June 30th.

☐ Health Care ($2,550 per person maximum) Annual Election: _____

☐ Dependent Care ($5,000 household maximum) Annual Election: _____

Legal Plan Enrollment

☐ New Coverage
☐ Change of Existing Coverage
☐ Cancel Coverage
☐ No change to Coverage
☐ Waive

Select coverage:

☐ Legal (Ultimate Advisor)
☐ Legal (Ultimate Advisor Plus)

Supplemental Insurance

To elect new coverage, change or cancel existing coverage, or receive additional information, please contact Aflac at 800-992-3624 or visit the Aflac website https://enrollment.aflac.com/AccountSites/V_X/wakeforest/Homepage.aspx (plan number: HK989).

☐ I am interested and will inquire on-line. ☐ I am not interested at this time. ☐ I would like to cancel my plan.

Group Long Term Care Insurance

To elect new coverage, change or cancel existing coverage, or receive additional information, please contact Genworth at 800-416-3624 or visit the Genworth website https://longtermcare.genworth.com/fiveseries/login.do (group id = **wakeforest** & code = **groupltc**).

☐ I am interested and will inquire on-line. ☐ I am not interested at this time. ☐ I would like to cancel my plan.

Reason for Completing Form

☐ New Hire ☐ Marriage ☐ Divorce/Legal Separation ☐ Birth/Adoption of Child ☐ Ineligible Dependent ☐ Employment/Benefit Change

Qualifying Event

If you are experiencing a qualifying event, you have 30 days from the event date to make changes to your benefit elections, and provide supporting documentation. If you are removing a spouse and/or dependent children, review your life insurance elections and complete a Life Insurance Enrollment Form, if applicable. Refunds will not be provided if submitted after 30 days from the event date.

Date of Event: _____

Pre-Tax Premium Plan

By signing below, I elect to have premiums for my medical, medical surcharge, dental, vision, flex spending account(s) and Supplemental Medical Coverage-Aflac 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: _____

Reviewed & Entered by:_____ **Date:** _____ **Payroll Effective Date:** _____ **Coverage Date:** _____