Enrollment Form

THE POOL
Transforming Your Wellbeing Together

OPEN ENROLLMENT FORM (FACULTY)

Name of employer/plan sponsor: WMHIP – Lake Superior State University Faculty					**Group #:** 71565
Enrollment Type & Employment Info	**Check one:**	☐ Initial	☐ Change	☐ Termination	☐ Reinstatement
	Reason for change (check all that apply): ☐ Initial Eligibility Following Hire ☐ **Open Enrollment** ☐ Status Change: _____ ☐ Other: _____				**Date of hire:** **Occupation:** **Hours worked weekly:** **Effective date of coverage or change: 1/1/2026**

Employee Information	**Employee Name (last, first, middle initial):**	**Gender:** ☐ Female ☐ Male	**Date of Birth:**	**Social Security Number:**
	Street Address:	**Telephone (including area code):**		
	City:	**Work:**	**Home:**	
	State: / **Zip Code:**	**Email Address:**		

Medical Plan Choice: (costs per pay period)

	PPO-26F Value 250 219
Employee	☐ $77.57
Employee + 1	☐ $174.53
Family	☐ $217.19

Waive Coverage:
☐ Waive coverage

Opt-Out Coverage:
☐ Opt-Out coverage ($100/per pay period cash in lieu payment)

To be eligible for Opt-Out, the employee must not be covered as primary or as a dependent on an LSSU sponsored medical/dental/vision plan.

FSA Election: (only for PPO-26 plan)

Medical Annual Employee Contribution:
$_____

Dependent Care Annual Employee Contribution:
$_____

2026 FSA Limits:
$3,400 for Medical or Limited Purpose FSA

$7,500 for Dependent Care

Dental & Vision Choice: (costs per pay)

	Dental & Vision
Employee	☐ $2.66
Employee + 1	☐ $5.33
Family	☐ $9.24

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Dependent's Name	Relationship to Child	Birth Date	Social Security Number	Gender	Add to Coverage
Spouse:				☐ Female ☐ Male	☐ Medical ☐ Dental ☐ Vision
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	☐ Medical ☐ Dental ☐ Vision
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	☐ Medical ☐ Dental ☐ Vision
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	☐ Medical ☐ Dental ☐ Vision
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	☐ Medical ☐ Dental ☐ Vision
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	☐ Medical ☐ Dental ☐ Vision

Employee certification and signature:

- To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent's status.
- The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings.
- I understand that under IRS regulations, I cannot change or revoke this election during the plan year unless I experience a "change in status" or other such events permitted by the Plan. I understand that it is my responsibility to notify the Human Resource Department of a Special Enrollment Event within 30 days of the Event taking place.
- **I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.**
- I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply.
- I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements.
- I understand that rates are effective in the first paycheck of 2026 which corresponds to the first pay period of 2026 (1/9/2026).

Employee signature:	Date: