

Enrollment Form

Name of employer/plan sponsor: WMHIP – Lake Superior State University Administrative & Professionals					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: 1/1/27											
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)	<table border="0"> <tr> <td></td> <td> <u>PPO-500 172</u> Employee ☐ \$92.10 Employee + 1 ☐ \$207.23 Family ☐ \$257.89 </td> <td> <u>HD 1750 108/09</u> ☐ \$80.34 ☐ \$180.75 ☐ \$224.94 </td> <td> <u>HD 3000 183/84</u> ☐ \$49.06 ☐ \$110.38 ☐ \$137.36 </td> <td> <u>HD 6350 157</u> ☐ \$42.13 ☐ \$94.80 ☐ \$117.97 </td> </tr> </table> <u>Waive Coverage:</u> ☐ Waive coverage <u>Opt-Out Coverage:</u> ☐ Opt-Out coverage (\$100/per pay period cash in lieu payment)							<u>PPO-500 172</u> Employee ☐ \$92.10 Employee + 1 ☐ \$207.23 Family ☐ \$257.89	<u>HD 1750 108/09</u> ☐ \$80.34 ☐ \$180.75 ☐ \$224.94	<u>HD 3000 183/84</u> ☐ \$49.06 ☐ \$110.38 ☐ \$137.36	<u>HD 6350 157</u> ☐ \$42.13 ☐ \$94.80 ☐ \$117.97
	<u>PPO-500 172</u> Employee ☐ \$92.10 Employee + 1 ☐ \$207.23 Family ☐ \$257.89	<u>HD 1750 108/09</u> ☐ \$80.34 ☐ \$180.75 ☐ \$224.94	<u>HD 3000 183/84</u> ☐ \$49.06 ☐ \$110.38 ☐ \$137.36	<u>HD 6350 157</u> ☐ \$42.13 ☐ \$94.80 ☐ \$117.97							
HSA Election: (*only for HD plans)	<u>Annual Employee Contribution:</u> \$ _____		<u>Per Pay Employee Contribution:</u> \$ _____		<u>2027 HSA Limits (employee + employer amounts):</u> Self-Only = \$4,500 annual 2 Person & Family = \$9,000 annual <i>*Catch-up contribution (age 55+): additional \$1,000/year</i> <i>Per pay contribution is annual contribution divided by pay periods remaining in the year, max of 24 pays for contribution deductions.</i>						
FSA Election:	<u>Medical Annual Employee Contribution (*only for PPO-500 Plan):</u> \$ _____	<u>Dependent Care Annual Employee Contribution:</u> \$ _____	<u>Limited Purpose Annual Employee Contribution:</u> \$ _____	<u>2027 FSA Limits:</u> \$3,400 for Medical or Limited Purpose FSA (pending IRS adjustment) \$7,500 for Dependent Care							
Dental & Vision Choice: (costs per pay)	Employee Employee + 1 Family	<u>Dental & Vision</u> ☐ \$3.58 ☐ \$7.15 ☐ \$12.42 ☐ Opt-Out									

Enrollment Form

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.

Employee signature:

Date: