

Enrollment/Change Benefits Form for Western Iowa Tech Community College

Section A – Enrollment/Change Information: **Effective Date:** _____

- Open Enrollment
- New Enrollment
- Reinstatement

- Change:** **Effective Date of Change** _____
- Cancel Employee Name Change
 - Add Dependent(s) Address Change
 - Cancel Dependent(s) Transfer to COBRA
 - Employee Terminated Move to Retiree Status
 - Part-time to Full-time Family Security Benefit/Surviving Spouse

If Change, please check reason for change:

- Marriage date _____
- Birth date _____
- Retired date _____
- Part-time to Full-time date _____
- Employee Termination date _____
- Other date _____ (please specify reason) _____
- Divorce date _____
- Employee Deceased date _____

Section B – Employee Information:

EMPLOYEE NAME (Last)	(First)	(MI)	SS#	GENDER	MARITAL STATUS	DATE OF HIRE
EMPLOYEE DATE OF BIRTH	HOME PHONE	WORK PHONE	E-MAIL ADDRESS		POSITION	
ADDRESS (Street)	(City)		(State)		(Zip Code)	

I WOULD LIKE TO ADD/CANCEL DEPENDENT COVERAGE FOR THE FOLLOWING DEPENDENTS:

(Last Name)	(First Name)	(MI)	(Relationship)	Gender	SS#	DOB	(Medical, Dental, Vision)	Add	Cancel	Student
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> A	<input type="checkbox"/> C	<input type="checkbox"/> Yes
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> A	<input type="checkbox"/> C	<input type="checkbox"/> Yes
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> A	<input type="checkbox"/> C	<input type="checkbox"/> Yes
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> A	<input type="checkbox"/> C	<input type="checkbox"/> Yes
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> A	<input type="checkbox"/> C	<input type="checkbox"/> Yes

Section C – MEDICAL Level of Coverage

- Employee Only Employee + Family

PLAN Options:

- \$500 Copay HDHP \$2500 – HSA Compatible
 Decline Medical Coverage

Section D – DENTAL Level of Coverage

- Employee Only Employee + Family

PLAN Options:

- Dental Plan Decline Dental Coverage

Section E – VISION Level of Coverage

- Employee Only Employee + Child(ren)
 Employee + Spouse Employee + Family

PLAN Options:

- Materials Only Vision Plan
 Decline Vision Coverage

Pursuant to the terms of the Western Iowa Tech Community College Cafeteria Benefits Plan, I elect to reduce my compensation for premiums as selective above.

I elect not to participate in the insurance premium conversion.

The Health, Dental, and Vision Insurance Premium Conversion election is irrevocable in a calendar year unless I have a significant increase (or decrease) in the Health, Dental, and Vision Insurance Plan premium or a change in family status as defined in Section 3.06 of the Cafeteria Spending Plan. Unless I revoke this election, the Plan automatically will increase my salary reduction to reflect premium increases. The Election for Health, Dental, and Vision Insurance Premiums will continue from year to year unless I revoke the agreement or I execute a new agreement. Except for a change in family status, a revocation or new agreement may be effective only as of the first payday in a calendar year.

Section F – Other Health Care Coverages:

If insuring under your health plans, do you or your dependents have other health insurance under an employer group plan or Medicare? Y N

If yes, please provide the following:

Name of Person Covered	SS#	Type of Other Health Insurance		Effective Date
_____	_____	<input type="checkbox"/> Medicare Part A	<input type="checkbox"/> Medicaid	_____
		<input type="checkbox"/> Medicare Part B	<input type="checkbox"/> Other _____	

Section G – Life and AD&D Beneficiary Designation:

	(First & Last Name)	(Date of Birth)	(SSN)	(Relationship)	(Percentage)
<u>Primary</u>	_____	_____	_____	_____	_____
<u>Contingent</u>	_____	_____	_____	_____	_____
<u>Contingent</u>	_____	_____	_____	_____	_____

Section H – SIGNATURE:

The information provided above is true and correct to the best of my knowledge, and I accept the provisions which I have read and understand. I authorize the proper payroll deductions (if any) from my earnings as my contribution towards the cost of coverage elected.

Employee's Signature / Date

Employer's Signature / Date