

# Employees Direct Summary Enrollment Form -- 2010

Name \_\_\_\_\_ MSU ID# \_\_\_\_\_  
(Last) (First) (MI)

Department \_\_\_\_\_ Campus Phone \_\_\_\_\_

- Complete all six (6) sections listed below, sign, and return to Human Resources, 404 Sparks Hall.
- Dropping or adding dependents, or changing coverage, please complete the appropriate enrollment form.

## 1. HEALTH INSURANCE – Complete Anthem Blue Cross & Blue Shield membership application if changing coverage.

I wish to continue my 2009 Standard or Enhanced health insurance choice for 2010. **If I had Basic coverage in 2009, I elect High Deductible Health Plan (HDHP) in 2010.**

Monthly Employee Costs	*HDHP (C)	**Blue Access Standard PPO (A)	**Blue Access Enhanced PPO (B)	Opt Out (Waiving Health Coverage)
Employee Only	<input type="checkbox"/> \$ 0	<input type="checkbox"/> \$27	<input type="checkbox"/> \$92	<input type="checkbox"/> I wish to opt out of MSU's health insurance coverage.  Covered by: <input type="checkbox"/> Spouse's Insurance  <input type="checkbox"/> Other _____
Employee+Child(ren)	<input type="checkbox"/> \$14	<input type="checkbox"/> \$94	<input type="checkbox"/> \$202	
Employee+Spouse	<input type="checkbox"/> \$17	<input type="checkbox"/> \$106	<input type="checkbox"/> \$226	
Employee+Spouse+Child(ren)	<input type="checkbox"/> \$56	<input type="checkbox"/> \$188	<input type="checkbox"/> \$368	

## 2. DENTAL INSURANCE

- Yes - I wish to continue my 2009 Dental insurance choice for 2010.
- I wish to change my dental coverage to:  
(Attach Completed Dental Form)
- |  |               |                                  |                                  |                                   |
|--|---------------|----------------------------------|----------------------------------|-----------------------------------|
|  | Employee Only | <u>Standard</u>                  | <u>Enhanced</u>                  | Opt Out (Waiving Dental Coverage) |
|  |               | <input type="checkbox"/> \$18.43 | <input type="checkbox"/> \$31.31 | _____                             |
|  | Family        | <input type="checkbox"/> \$54.95 | <input type="checkbox"/> \$81.87 | <input type="checkbox"/>          |

## 3. \*HEALTH SAVINGS ACCOUNT (Must have HDHP to have HSA)

- I wish to participate in the HSA in 2010.
- Yes - (Attach Completed HSA Enrollment Form)  
(ACS/Mellon Bank Acct. Inf. Will be Mailed)
- No
- |  |  |  |
|--|--|--|
|  | Minimum Per Pay: Bi-weekly \$5; Annually \$130<br>Minimum Per Pay: Monthly \$11; Annually \$132<br>Maximum Per Year: Single \$3,050; Family \$6,150<br>(Add \$1,000 to Maximum if Age 55 or Older) | \$ _____<br><b>Annual Contribution</b> |
|--|--|--|

## 4. \*\*HEALTH CARE FLEXIBLE SPENDING ACCOUNT – (Medical Spending)

- I wish to participate in 2010. (Cannot have HDHP Health Coverage to Enroll in Medical FSA)
- Yes - (Attach Completed WageWorks Enrollment Form)
- No
- |  |                               |  |
|--|-------------------------------|--|
|  | Minimum \$50; maximum \$5,000 | \$ _____<br><b>Annual Contribution</b> |
|--|-------------------------------|--|

## 5. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT – (Day Care)

- I wish to participate in 2010.
- Yes - (Attach Completed WageWorks Enrollment Form)
- No
- |  |                               |  |
|--|-------------------------------|--|
|  | Minimum \$50; Maximum \$5,000 | \$ _____<br><b>Annual Contribution</b> |
|--|-------------------------------|--|

## 6. SICK LEAVE BANK – Balance of six (6) sick days required to initially participate.

- Yes – I am a current member of the sick leave bank and wish to continue for 2010. No contribution required.
- Yes – I am not a member of the sick leave bank and wish to join for 2010. A contribution of (1) day is required.
- No – I do not wish to be a member of the sick leave bank in 2010.

## AUTHORIZATION

I hereby authorize Murray State University to deduct from my pay my share of the costs, if any, of the benefits I have selected above. Furthermore, I understand that I cannot make changes until the next open enrollment period unless I have a change in family status, in which case **forms must be signed and changes must be made in Human Resources within 30 days**. I understand that my sick leave bank donation is irrevocable and I cannot assign the donation to any specific individual. I certify that the information provided above is true and accurate to the best of my knowledge.

I may obtain a copy of the HIPAA Privacy Notice for the MSU Employee Health Plan (Anthem Blue Cross/Blue Shield) and WageWorks Corporation by contacting the MSU Human Resources Department, 404 Sparks Hall, 809-2146.

Signature \_\_\_\_\_ Date \_\_\_\_\_