Walla Walla University ☐ Full Time ☐ Part Time

WWU Benefit Enrollment Form 2025-26

Event Type: ☐ New Hire ☐ Birth/Adoption ☐ Legal Guardianship ☐ Marriage
☐ Divorce ☐ Death of Spouse/Dependent ☐ Address/Name Change ☐ Open Enrollment
☐ Employee, Spouse, Dependent Loss/Gain of Coverage (refer to section #D)

Instructions: This form provides you with the different election options. You must complete this form and return it to Human Resources. Complete and indicate your benefit choice by checking the box next to the desired benefit options.

A. Employee Information			
First Name:		**Last Name:**	
ID:		**Date of Hire:**	
SSN:		**Effective Date:**	
Address:		**City, State, Zip:**	
Date of Birth:		**Home Phone:**	
Job Title:		**Hours Worked:**	
Gender:	☐ Male ☐ Female	**Marital Status:**	
(Office Use Only) Class:		(Office Use Only) Subgroup:	

B. Employee Health Plan Selections – *Select one of two options below:*

1. Medical/Rx/Dental/Vision – **Your Monthly Premiums**

Option 1: Premera High Deductible Health Plan with Health Savings Account (HSA), Delta Dental, VSP	**HDHP Premium Per Month**	**Option 2: Premera Copay PPO Plan, Delta Dental, VSP**	**COPAY Premium Per Month**
☐ **Employee Only**	$71.15	☐ **Employee Only**	$133.31
☐ **Employee + Spouse***	$149.44	☐ **Employee + Spouse***	$263.98
☐ **Employee + Child(ren)**	$128.09	☐ **Employee + Child(ren)**	$212.56
☐ **Employee + Family***	$193.77	☐ **Employee + Family***	$269.46

*Spouses may only enroll in WWU-provided plans if they do not have access to purchase employer-provided health insurance. Verification from the spouse's employer confirming lack of coverage eligibility is required annually.

If you select the HDHP coverage, you are automatically enrolled in a Health Savings Account (HSA) with Optum Financial. WWU contributes $650 for those electing *Employee Only* and $1,300 for those electing *Employee +* coverage. You may make additional contributions up to the IRS maximum per calendar year. WWU's election plus yours must not exceed the annual IRS limit. An HSA is not permitted if an employee is also covered by another non-qualified health plan, enrolled in a Healthcare Flexible Spending Account, Medicare, Medicaid, or Tricare.

Health Savings Account – Optum Financial		
Enroll:	Employee Annual Election Amount (Payroll deduction)	2025 IRS Maximum Annual Election
☐ Yes ☐ Waive (Currently enrolled in another non-qualified health plan, a Flexible Spending Account, Medicare, Medicaid, or Tricare.)		Maximum of $4,300 for employee only; $8,550 for employee + dependent(s) for calendar year 2025

2. I elect to waive health care coverage because (choose one of the following):
☐ I am participating in my Spouse's plan
☐ I am participating in my Parent's plan
☐ Other _____

Please provide proof of other coverage.

C. Dependent Enrollment Information

Dependent's Name First MI Last	Date of Birth	Social Security #	Relationship	Gender	Medical/Rx/ Dental/Vision
			☐ Spouse ☐ Child	☐ M ☐ F	☐ Add ☐ Remove
			☐ Spouse ☐ Child	☐ M ☐ F	☐ Add ☐ Remove
			☐ Spouse ☐ Child	☐ M ☐ F	☐ Add ☐ Remove
			☐ Spouse ☐ Child	☐ M ☐ F	☐ Add ☐ Remove
			☐ Spouse ☐ Child	☐ M ☐ F	☐ Add ☐ Remove

If any dependents do not reside with you, please list their address:

_____
Dependent Name

_____
Address City State Zip

D. Other Current Coverage Information:

Please indicate for each person listed on this application any health insurance (including Medicare and Medicaid) that will continue while covered under the WWU plan.

Applicant's Name	Insurance Company Name, Policy Number and Phone Number	Date of Coverage	Coverage Continuing?	Type of Coverage	Type of Product	Medicare
		Begin: End:	☐Yes ☐No	☐ Group ☐ Individual	☐ Medical ☐ Dental	☐ Part A ☐ Part B ☐ Part D
		Begin: End:	☐Yes ☐No	☐ Group ☐ Individual	☐ Medical ☐ Dental	☐ Part A ☐ Part B ☐ Part D
		Begin: End:	☐Yes ☐No	☐ Group ☐ Individual	☐ Medical ☐ Dental	☐ Part A ☐ Part B ☐ Part D

E. Life, Accidental Death & Dismemberment (AD&D), and Long-Term Disability & EAP

Employer Paid

All full-time employees are automatically enrolled in Basic Life, AD&D and Long-Term Disability. Coverage includes: $100,000 of life insurance and 100,000 of AD&D for employee, $50,000 of life insurance for spouse, $10,000 of life insurance per each dependent under the age of 26, and long-term disability pays up to 66.67% of your total monthly earnings if you become disabled.

Voluntary Life – Reliance Matrix (Full-Time and Part-Time)	Voluntary AD&D – Reliance Matrix (Full-Time and Part-Time)
Employee Paid – Guaranteed Issue for newly eligible employees is $150,000 and $30,000 for spouses ***Note**: Evidence of insurability (EOI) may be required before coverage is approved*	
☐ Employee Coverage ($10,000 to $500,000, increments of $10,000) Election Amount: _____ ☐ Decline Voluntary Employee Life Coverage	☐ Employee Coverage ($10,000 to $500,000, increments of $10,000) Election Amount: _____ ☐ Decline Voluntary Employee AD&D Coverage
☐ Spouse Coverage ($10,000 to $250,000, increments of $10,000) Election Amount: _____ ☐ Decline Voluntary Spouse Life Coverage	☐ Spouse Coverage ($10,000 to $250,000, increments of $10,000) Election Amount: _____ ☐ Decline Voluntary Spouse AD&D Coverage
☐ Child(ren) Coverage ($5,000 to 10,000, maximum of $10,000) Election Amount: _____ ☐ Decline Voluntary Dependent Life Coverage	☐ Child(ren) Coverage (5,000 to 10,000, maximum of $10,000) Election Amount: _____ ☐ Decline Voluntary Dependent AD&D Coverage

F. Beneficiary Designation for Basic and Voluntary Life/Accidental Death and Dismemberment (AD&D)					
	Name, Address and Phone Number	Relationship	Date of Birth	Social Security Number	Percentage
Primary Beneficiary					
Primary Beneficiary					
Contingent Beneficiary					
Contingent Beneficiary					
Contingent Beneficiary					

Acknowledgements

I hereby apply for enrollment, change, or termination of coverage as indicated above. Any coverage will be under the master contract between the carrier and my employer and subject to the terms and conditions of the certificate issued under it. I agree to the employer's enrollment provisions and certify that those I seek to enroll meet the eligibility criteria. I understand that coverage does not start until I serve the employer's eligibility waiting period established in the carriers' records.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee Signature **Date**

Medical benefits underwritten by Premera Blue Cross.
Vision benefits underwritten by Vision Service Plan.
Dental benefits underwritten by Delta Dental of Washington.
Life/AD&D & Disability benefits underwritten by Reliance Matrix.

Premera Blue Cross
PO Box 91060
Seattle, WA 98111

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Delta Dental of Washington
PO Box 75688
Seattle, WA 98175

Reliance Matrix
1700 Market Street, Suite 1200
Philadelphia, PA 19103