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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of employer/plan sponsor:** WMHIP – INSERT GROUP NAME | | | | | | | | | | | 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:** | | | | | | | |
| **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) | Employee  Employee + 1  Family | | **Buy-Up:**  🞏 $0.00  🞏 $40.73  🞏 $13.05 | | | | **HSA 1\*:**  🞏 $0.00  🞏 $0.00  🞏 $0.00 | | | | | **HSA 2\*:**  🞏 $0.00  🞏 $0.00  🞏 $0.00 | | | | | | **Opt-Out:**  🞏 Waive coverage |
| **HSA Election:**  (\*only for HSA plans) | **Annual Employee Contribution:**  $\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **Per Pay Employee Contribution:**  (÷26) = $\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **2025 HSA Limits:**  **Self-Only = $4,300 annual ($165.38 per pay)**  **2 Person & Family = $8,300 annual ($328.84 per pay)**  *\*Catch-up contribution (age 55+): additional $1,000/year* | | | | | | | | | |
| **Dental Choice:**  (costs per pay) | Employee  Employee + 1  Family | | **Dental:**  🞏 $0.00  🞏 $0.00  🞏 $0.00 | | | | | | **Vision**  **Plan Choice:**  (costs per pay) | | | | | Employee  Employee + 1  Family | | | **VSP:**  🞏 $1.29  🞏 $2.45  🞏 $3.60 | |

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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 |

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| **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:** |