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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) | EmployeeEmployee + 1Family | **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) | EmployeeEmployee + 1Family | **Dental:**🞏 $0.00🞏 $0.00🞏 $0.00 | **Vision** **Plan Choice:** (costs per pay) | EmployeeEmployee + 1Family | **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.
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| **Employee signature:** | **Date:** |