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Seattle Pacific UNIVERSITY

Insurance Enrollment and Change Form

For the 2021 Plan Year

For most: Complete no more than 30 days after hire or change event

Coverage Effective Date (MM/DD/YYYY) ______________________________

Employee Information:

LEGAL First Name:________________________ Middle Initial:____ LEGAL Last Name:________________________________

SSN: ____________________________ SPU ID#: ______________________ FTE%: ___________ Gender: ☐F ☐M

Address: ____ City:____________________ State:______

Zip:___________ Birthdate (MM/DD/YYYY)__________________________ Marital Status: ☐Single ☐Married

Reason for Change:

☐ Initial Enrollment — Date of Hire: ______________________________________

☐ Mid-Year Change — Describe: ____(*e.g.*, gaining or losing a dependent due to birth/death, marriage/divorce, etc.; a dependent gaining or losing access to an insurance plan; a change in your FTE%; or a change in plan coverage due to a dependent's Open Enrollment. Other events may qualify, please contact Human Resources.)

Dependent Information (complete if you are adding/dropping from insurance):

Spouse

Legal Name	Date of Birth	SSN	Gender	Medical	Dental	Vision
________________________	__________________	___________________	☐ Male ☐ Female	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop

Dependent Children that are eligible for coverage must be less than 26 years of age and the employee's and/or spouse's natural offspring, adopted child, or child placed for adoption or a legal ward. A child 26 or older may still be covered as a dependent if unmarried and developmentally or physically disabled. Please contact Human Resources if this is the case.

Legal Name	Date of Birth	SSN	Gender	Medical	Dental	Vision
________________________	__________________	___________________	☐ Male ☐ Female	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
________________________	__________________	___________________	☐ Male ☐ Female	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
________________________	__________________	___________________	☐ Male ☐ Female	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
________________________	__________________	___________________	☐ Male ☐ Female	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
________________________	__________________	___________________	☐ Male ☐ Female	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
________________________	__________________	___________________	☐ Male ☐ Female	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
________________________	__________________	___________________	☐ Male ☐ Female	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
________________________	__________________	___________________	☐ Male ☐ Female	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop

Health Benefits Selections:

	Medical		Dental		Vision
	☐ Change ☐ No Change ☐ New ☐ Waive		☐ Change ☐ No Change ☐ New ☐ Waive		☐ Change ☐ No Change ☐ New
Coverage Type	**High Deductible Health Plan (HDHP)**				
	Full-time	*Part-time*	*Full-time*	*Part-time*	
Employee Only	☐ $0	☐ $220	☐ $0	☐ $20	☐ $0
Employee + Spouse	☐ $414	☐ $634	☐ $58	☐ $78	☐ $10
Employee + Children	☐ $136	☐ $356	☐ $56	☐ $76	☐ $12
Employee + Family	☐ $640	☐ $860	☐ $114	☐ $134	☐ $24

Health Savings Account (HSA)

	IRS Calendar Year Max	SPU Monthly Contributions	Dollar-for-Dollar Match
Individual	$3,600	$84	Up to $400
Family	$7,200	$168	Up to $800

To enroll in the Health Savings Account (HSA), I hereby agree to the following terms and conditions:

☐ I must be enrolled in the High Deductible Health Plan (HDHP).

To receive contributions from either SPU or myself, I must meet the following conditions:

☐ I must not be enrolled on any part of Medicare (NOTE: If you are over age 65 and enroll in Social Security benefits, you will automatically be enrolled in Medicare Part A, often six months prior);

☐ I must not be covered under other health insurance unless it also is a HSA-qualified High Deductible Health Plan (HDHP);

☐ Neither I or my spouse can have a Health Flexible Spending Account (FSA) while I make or receive HSA contributions;

☐ I must not be claimed as a dependent on someone else's tax return.

I would like to have the following contributions made to my HSA:

☐ SPU contributions, and

☐ My own contributions of $ _____ per pay-period.

Health Reimbursement Account (HRA)

	2021 SPU Annual Contribution
Individual	$1,008
Family	$2,012

Amounts based on 12 months of participation. If enrolling mid-year, this amount will be pro-rated based on the number of eligible months left in the plan year.

Before I can elect to participate in the Health Reimbursement Account (HRA), I must agree to the following terms and conditions:

☐ I must be enrolled in the High Deductible Health Plan (HDHP).

Will you have Individual or Family coverage during 2021?

☐ Individual ☐ Family

*Please note, HRA funds may only be used to covered the qualified health expenses of those dependents that are actually enrolled on the SPU medical plan as a dependent.

Flexible Spending Accounts

	Amount per pay period		# checks remaining		Annual Total	Annual Max	
Health FSA	$	x		= $	0.00	***$2,750***	Health FSA funds must be reimbursed for qualifying health expenses during the plan year, otherwise they are forfeit.
Limited Purpose FSA	$	x		= $	0.00	***$2,750***	LP FSAs are for dental and vision expenses only alongside an HSA.
Dependent Care FSA (Child/Elder)*	$	x		= $	0.00	***$5,000***	*If you are married and filing separately or your spouse is a full-time student or incapable of self-care, contact HR at (206) 281-2809.

Signature Authority

I have read and understood my benefits choices. My signature below authorizes the selections I have made and any pre-tax salary reduction required to pay for my selections. I understand that I cannot change my selections until Open Enrollment unless I or my dependents experience an involuntary loss of coverage, gain new coverage for which we were previously ineligible, or experience a qualifying change in family status. I also acknowledge that any dependent children I am covering meet the Dependent Child definition in the Dependent (Spouse/Children) Information section above.

Employee Signature _____ **Date** _____

Office Use Only

	Date		Date		Date		Date
PBF ☐		PDABENE ☐		Aetna ☐		HSA ☐	
PBF (HSA) ☐		PDABCOV ☐		Delta Dental ☐		Bank ☐	
PPAIDEN ☐		PDAHIOC ☐		VSP ☐			