

Westminster College Enrollment/Change Form

Westminster College 1840 South 1300 East, Salt Lake City, UT 84105

Type of Change or Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Name Change	<input type="checkbox"/> Marriage date / /	<input type="checkbox"/> Other
	<input type="checkbox"/> Adoption	<input type="checkbox"/> Birth date of Child / /			<input type="checkbox"/> Divorce date / /

Employee Last Name	First Name	MI	Social Security Number - - -
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Home Address			Notes:
City	County	State	
Zip Code			

Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed	E-mail address:
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Employee & Dependent Information (Use a separate form if more than 6 children)

Last Name	First Name	MI	Gender	Social Security Number	Birth date	Age	Add (A) or Delete (D)		
							Medical	Dental	Vision
Employee			M / F	- - -	- - -				
Spouse			M / F	- - -	- - -				
Child 1			M / F	- - -	- - -				
Child 2			M / F	- - -	- - -				
Child 3			M / F	- - -	- - -				
Child 4			M / F	- - -	- - -				
Child 5			M / F	- - -	- - -				
Child 6			M / F	- - -	- - -				

Reason for Deletion: _____
 Any eligible family member not listed on this application will be considered to be waived coverage

Check appropriate box for desired coverage.

	Altius Health Plans		MetLife	EyeMed	National Benefit Services (NBS)		HWAC
	MEDICAL		DENTAL	VISION	REIMBURSEMENT ACCOUNTS		HWAC
	Altius Peak Advantage	Altius Peak HMO	MetLife Dental	EyeMed Vision	Health Care Reimbursement Account	Dependent Care Reimbursement Account	Dolores Dore Eccles Health, Wellness, and Athletic Center
Single	<input type="checkbox"/> \$20.06	<input type="checkbox"/> \$0	<input type="checkbox"/> \$0	<input type="checkbox"/> \$8.01	Maximum Contribution \$200/month	Maximum Contribution \$416.66/month married, \$208.33/month single	<input type="checkbox"/> \$12.50
2 Party	<input type="checkbox"/> \$161.54	<input type="checkbox"/> \$124.48	<input type="checkbox"/> \$26.70	<input type="checkbox"/> \$15.13			<input type="checkbox"/> \$10.00
Family	<input type="checkbox"/> \$212.26	<input type="checkbox"/> \$167.96	<input type="checkbox"/> \$33.40	<input type="checkbox"/> \$22.18			no family plan available
Monthly Deduction	\$	\$	\$	\$	\$	\$	\$

VOLUNTARY LIFE INSURANCE:	<input type="checkbox"/>	Check if desired - requires separate enrollment form to be completed - see Voluntary Life rate sheet. Indicate monthly premium for desired coverage from rate sheet at right. → → → →		\$
COLONIAL COVERAGE:	<input type="checkbox"/>	Check if desired - requires separate enrollment form to be completed - see Colonial rate sheet. Indicate monthly premium for desired coverage from rate sheet at right. → → → →		\$
LONG TERM CARE:	<input type="checkbox"/>	Check if desired - requires separate enrollment form to be completed - see Long Term Care rate sheet. Indicate monthly premium for desired coverage from rate sheet at right. → → → →		\$

The following coverages have been offered to me and after careful consideration I have decided that I wish to decline:

Medical Dental Vision Long Term Care Voluntary Life/AD&D
 Colonial Cancer Security Colonial Accident Colonial Critical Illness
 Health Care Account Dependent Care Account

Signature for declining any coverages _____ **Date** _____

Do you or another family member have health coverage through another group or Medicare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please complete this section
Name of Policy Holder	Group Name	Group #	
Covered Member's Employer			

EMPLOYEE MUST READ AND COMPLETE THIS SECTION

I authorize any source to release to my insurance carrier any medical, health, employment, and/or insurance information required on ANY enrolled member. I understand and agree that **my contributions for medical, dental, and vision coverage will be made on a pre-tax basis**, and that I may not change medical, dental, or vision elections unless I have a status change as defined by the IRS regulations, or at the next open enrollment. **All other contributions will be on an after-tax basis.** I hereby apply for benefits under my employer's group benefits plan(s), or decline coverage, as indicated. I authorize payroll deductions, if required, for the cost of coverage I have selected. If applying for Altius Mountain HMO, I understand that each covered family member must select a participating Primary Care Physician (PCP). The selected PCP and Insurance Company will provide or direct all medical care. I understand there may not be participating providers in all specialty fields.

DECLINING COVERAGE: If you wish to waive any coverage at this time, you and your dependents may not again be eligible to enroll in these plans until the next open enrollment period established by Westminster College, or without, for some coverage, providing evidence of good health. If you are declining enrollment for yourself and your dependents (including your spouse) because of other health, dental, and/or vision insurance coverage, you may in the future be able to enroll yourself and your dependents in these plans, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse, and any dependent child(ren) newly acquired by such marriage, birth, adoption, or placement for adoption, provided that you request enrollment within 30 days after the marriage or after the date of birth, adoption or placement for adoption.

SEE THE FULL PLAN DESCRIPTION FOR DETAILS OF ELIGIBILITY AND COVERAGE.

Employee Signature	Date
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Beneficiary Designation For Life Insurance

Primary Beneficiary	Relationship	SS#	
Street Address	City	State	Zip
Contingent Beneficiary	Relationship	SS#	
Street Address	City	State	Zip

NOTE: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you.