PRE-65 HEALTH ENROLLMENT FORM

WASHINGTON AND LEE UNIVERSITY

Effective Date of Coverage: **Email Address :**_____

Personal Information			
Employee/Spouse Name:			Social Security Number:
Mailing address:			Employee or Spouse:
			Home Phone: Cell Phone:
City:	State:		Zip Code:
Date of Birth:	Sex ☐ Female ☐ Male	Marital Status: ☐ Single ☐ Married	☐ Domestic Partnership

If you enroll your domestic partner in health or dental below, you must also complete a Declaration of Domestic Partnership on the HR website at http://www.wlu.edu/human-resources/benefits/about-our-benefits-program/domestic-partner-benefits.

MEDICAL PLAN: ENROLLMENT ELECTION INFORMATION

Aetna Medical / Rx (Check here if enrolling in medical OR complete medical waiver section.)

	Monthly	
☐ None / Waive*	$0.00	
☐ Employee/Spouse	$186.72	
☐ Employee + One	$420.11	
☐ Employee + Family	$485.31	

Medicare Eligibility Date:

Carve Out Plan: Yes ☐ No ☐

MEDICAL PLAN: WAIVE OR DROP MEDICAL COVERAGE

Please complete this section of you are waiving medical coverage. You MUST check at least one box below to indicate your reason and complete the Carrier Name and Group ID Number below.

☐ I have group medical insurance through my spouse's employer or my parents' plan. ☐ I have medical insurance through Medicare. ☐ Other:

☐ I am covered under a stand-alone medical policy (not through a group). ☐ I do not wish to have any medical coverage (no other coverage).

Carrier Name: Group ID Number:

(over)

DEPENDENT INFORMATION AND MEDICAL PLAN

CHOOSE ONLY 1 PLAN-if you do not choose a plan, you will be automatically be defaulted into the Aetna Choice POS II plan

Please complete the information requested below for all eligible dependent family members who you enroll in health and dental. Note: **Your children can be covered through the end of the month in which they reach age 26 regardless of their student or marital status.**

(A)dd/New (C)hange (R)emove	First Name	Middle Initial	Last Name	SSN	DOB	Relationship	Gender	Aetna Choice POS II	Aetna Choice POS II - Carilion
						SELF	☐M ☐F	☐	☐
						SPOUSE	☐M ☐F	☐	☐
						DOMESTIC PARTNER	☐M ☐F	☐	☐
						CHILD	☐M ☐F	☐	☐
						CHILD	☐M ☐F	☐	☐
						CHILD	☐M ☐F	☐	☐

I have read and understand the explanation that I have received regarding my options under the Washington and Lee University Benefit Plan. I understand that due to provider and/or IRS regulations, my Medical coverage elections are binding until either my employer changes the plan or the duration of the plan year, whichever comes first. I acknowledge that my election cannot be changed during the current plan year that ends on **June 30, 2022** unless there is a change in my family status. A change in family status includes; marriage, divorce, death of a spouse or dependent, birth or adoption of a child, or a change in your employment status or that of your spouse. **I understand that I must report any change in family status (marriage, divorce, death, birth, adoption, loss of prior coverage) that may impact my insurance coverage to the Human Resources within 31 days of the event.** I also understand that my employee and employer contributions to Social Security will be somewhat reduced because some of my pay deductions are being taken on a pre-tax basis.

Please sign the applicable statement(s) below

Signature: _____ **Date:** _____