Southwestern University 2025
Benefits New Employee/
Change Form For Monthly Paid
Employees

# 2025 Monthly

**Employee Information** ☐ **Check box if New Address or Phone**

Employee Name: (Last, First, Middle) **Please Print**

_____

Phone:_____

Address: (Street, City, State, Zip Code)

_____

Social Security #: _____-____-_____ Email: _____

Date of Birth: (mm/dd/yyyy) _____

Marital Status ☐ Single ☐ Married

☐ Male ☐ Female

| HR Use Only | Monthly Contribution |
|---|---|
| CONT | |

**Reason for Completing This Form** **(this change form & required documentation must be submitted to Human Resources within 30 days of qualifying event)**

- ☐ Open Enrollment
- ☐ New Hire
- ☐ Birth or Adoption
- ☐ Divorce
- ☐ Marriage
- ☐ COBRA
- ☐ Death of Spouse or Dependent
- ☐ Termination of other group health plan
- ☐ Change in Spouse/Dependent's employment status
- ☐ Qualified Medical Support Order
- ☐ Return from Leave of Absence
- ☐ Other _____
- ☐ Change in Health Savings Account (HSA) Deduction Amount Only (no qualifying event required)

Event Date: _____

Benefits Change
Effective Date: _____

**Medical** ☐ Yes, I wish to change my medical coverage. ☐ No, I do not wish to change my medical coverage. ☐ Waive Coverage

(Select ONE Dollar Amount) Note: All deductions are made on a Pre-Tax basis

Monthly Premium/Code _____

| Plan Choice: | Employee Only | Emp + Spouse | Emp + Child(ren) | Emp + Family |
|---|---|---|---|---|
| ☐ High Deductible Health Plan | ☐ $0.00 | ☐ $290.14 | ☐ $124.25 | ☐ $417.97 |
| ☐ Base PPO Plan | ☐ $109.00 | ☐ $415.51 | ☐ $217.99 | ☐ $601.12 |
| ☐ Buy-Up PPO Plan | ☐ $198.93 | ☐ $609.69 | ☐ $372.98 | ☐ $903.39 |

**Dental** ☐ Yes, I wish to change my dental coverage. ☐ No, I do not wish to change my dental coverage. ☐ Waive Coverage

(Select ONE Dollar Amount) Note: All deductions are made on a Pre-Tax basis

Monthly Premium/Code _____

| Plan Choice: | Employee Only | Emp+ Spouse | Emp +Child(ren) | Emp + Family |
|---|---|---|---|---|
| ☐ HUMANA PPO Low Plan (NO ortho) | ☐ $23.50 | ☐ $46.98 | ☐ $52.86 | ☐ $ 81.05 |
| ☐ HUMANA PPO High Plan (inc ortho) | ☐ $34.00 | ☐ $67.97 | ☐ $85.76 | ☐ $128.55 |

**Vision** ☐ Yes, I wish to change my vision coverage. ☐ No, I do not wish to change my vision coverage. ☐ Waive Coverage

(Select ONE Dollar Amount) Note: All deductions are made on a Pre-Tax basis

Monthly Premium/Code _____

| Plan Choice: | Employee Only | Emp + Spouse | Emp + Child(ren) | Emp + Family |
|---|---|---|---|---|
| ☐ HUMANA Vision | ☐ $6.38 | ☐ $12.74 | ☐ $12.11 | ☐ $19.03 |

**Subtotal amount to be deducted MONTHLY:**

Last name, first name, middle initial (print)

**Flexible Spending Accounts (FSA) / Health Savings Account (HSA) Election**

☐ Yes, I wish to elect a **dependent care Flexible Spending Account (FSA)** with a monthly contribution of : **$**_____**(DC)**
($5,000 annual limit/single or married if filing jointly or $2,500 if married filing separately).

☐ Decline **dependent care** flexible spending account.

☐ Yes, I wish to elect a **medical Flexible Spending Account (FSA)** with a**n ANNUAL** contribution of: ($3,200 annual limit). $_____**(SA)**
Do not choose this option if you enroll in the High Deductible Health Plan (HDHP). (Amount is divided by the months employed.

☐ Decline **medical care** flexible spending account.

☐ Yes, I wish to elect a **Health Savings Account (HSA).** You must enroll in the **HDHP** and complete this section to elect this coverage. Southwestern University will contribute ($75.00 single or $150.00 employee + dependent) on a monthly contribution if you choose to elect the HDHP/High Deductible Health Plan. $ _____ (HSER)

☐ In addition to what Southwestern University Contributes to my HSA, I elect a monthly contribution of: **$**_____**(HSEE)**
(not to exceed the annual maximum of $4,300 for employee only (max $3,400 employee contribution) or $8,550 for employee + dependent (max $6,750 employee contribution). A $1,000 catch up contribution is available for employees age 55 and over.

☐ I do NOT wish to contribute into my Health Savings Account.

**Term Life / AD&D Election and Optional Dependent Life Coverage Effective:** ____/____/2025

☐ Yes, I wish to elect **Term Life / AD&D Employee Coverage for 2 times my annual salary**:

Salary _____ X 2 = _____ Rounded Amount_____/1000=_____X .167=_____/2=_____ approx prem

☐ I Waive Term Life / AD&D Employee Coverage

**Optional Life Dependent Coverage**

☐ Yes, I wish to elect Optional Dependent Life Coverage

☐ Option One: $5.80 = $25,000/$10,000 of coverage ☐ Option Two: $2.40 $10,000/$5,000 of coverage

☐ I Waive Optional Dependent Life Coverage

**Total amount to be deducted MONTHLY:**

**Retirement Plan - TIAA/CREF Regular Retirement Plan 403(b)**

☐ Not Eligible until after one year waiting period: Effective Date of Coverage: _____

☐ Eligible as of : _____

☐ ELIGIBILITY PENDING UNTIL DOCUMENTATION IS RECEIVED AND VERIFIED. _____

**Family Information** (Medical, Dental & Vision) Complete the following information for dependents only if you are adding or deleting dependent coverage.

| Name | Add/ Drop | Sex M/F | Social Security Number | Birthdate (mm/dd/yyyy) | Married | Coverage |
|---|---|---|---|---|---|---|
| Spouse | ☐ A ☐ D | ☐ M ☐ F | | | N/A | ☐ Medical ☐ Dental ☐ Vision |
| Child | ☐ A ☐ D | ☐ M ☐ F | | | ☐ Y ☐ N | ☐ Medical ☐ Dental ☐ Vision |
| Child | ☐ A ☐ D | ☐ M ☐ F | | | ☐ Y ☐ N | ☐ Medical ☐ Dental ☐ Vision |
| Child | ☐ A ☐ D | ☐ M ☐ F | | | ☐ Y ☐ N | ☐ Medical ☐ Dental ☐ Vision |

Last name, first name, middle initial (print)

**Authorization - Including important information on HSA and FSA accounts**

- I authorize Southwestern University to make periodic salary reductions from my paycheck to be deposited in my account for the election period specified above in an amount equal to the premiums required for the coverage elected above plus the specific dollar amounts, if any, elected for the Flexible Spending Accounts and/or the Health Savings Account. The salary reductions will be made in substantially equal amounts, to the extent administratively feasible. I further authorize Discovery Benefits to disburse funds from my account in accordance with the Plan and my elections.
- I further acknowledge that I must submit Reimbursement Requests to receive reimbursement from my flexible spending account(s) if I did not utilize my debit card to pay for services. Additionally, I understand that there may be times that I will be required to provide an itemized receipt when my debit card is used.
- My elections (other than the Health Savings Account contributions), including coverage types, cannot be altered without a qualified "Change in Family Status" as defined by the Internal Revenue Code.
- The Southwestern University plan year runs from January 1, 2025 through December 31, 2025. The grace period for incurring Health Care and Dependent Care Flexible Spending Account expenses has been extended to March 15, 2026. The deadline for filing all claims will be April 30, 2026.
- The unused balance of the Flexible Spending Accounts is forfeited if unclaimed by April 30, 2026. I understand that if my employment terminates prior to March 15, 2026, the unused balance of the Flexible Spending Accounts is forfeited if unclaimed within 45 days following my termination date, unless otherwise extended under applicable continuation coverage rules.
- I hereby verify that, if I am married and have elected salary reduction contributions for the Dependent Care benefit in the amounts which will exceed $2,500 in one calendar year, I will file a joint income tax return with my spouse.
- By participating and pre-taxing the above premiums, the computing and reporting of my federal income tax will be based on my reduced salary, as will my FICA (social security) contributions.
- If I enroll in the HDHP and elect contributions to the Health Savings Account, I understand that I will be required to submit additional documentation to the custodian of the Health Savings Account in order to open, and have contributions made to, the Account. Further, I understand the applicable eligibility requirements for Health Savings Account contributions and confirm I am eligible to make such contributions and have contributions made on my behalf. I understand that I am solely responsible for any tax consequences related to my participation in the Health Savings Account.

Employee Signature

Date