



Southwestern University
2026 Benefits New Employee/
Change Form For Bi-Weekly
Paid Employees

2026
BiWeekly

Employee Information		<input type="checkbox"/> Check box if New Address or Phone					
Employee Name: (Last, First, Middle) Please Print _____ Phone: _____ Address: (Street, City, State, Zip Code) _____		Social Security #: ____-____-____ Date of Birth: (mm/dd/yyyy) Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Email: _____ <table border="1"><thead><tr><th>HR Use Only</th><th>MO/SM Contribution</th></tr></thead><tbody><tr><td>EBC</td><td></td></tr></tbody></table>	HR Use Only	MO/SM Contribution	EBC	
HR Use Only	MO/SM Contribution						
EBC							
Reason for Completing This Form (this change form & required documentation must be submitted to Human Resources within 30 days of qualifying event)							
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Marriage <input type="checkbox"/> COBRA		<input type="checkbox"/> Death of Spouse or Dependent <input type="checkbox"/> Termination of other group health plan <input type="checkbox"/> Change in Spouse/Dependent's employment status <input type="checkbox"/> Qualified Medical Support Order <input type="checkbox"/> Return from Leave of Absence <input type="checkbox"/> Other _____					
<input type="checkbox"/> Change in Health Savings Account (HSA) Deduction Amount Only (no qualifying event required) RventDate: _____ Benefits Change Effective Date: _____							
Medical <input type="checkbox"/> Yes, I wish to change my medical coverage. <input type="checkbox"/> No, I do not wish to change my medical coverage. <input type="checkbox"/> Waive Coverage							
(Select ONE Dollar Amount) Note: All deductions are made on a Pre-Tax basis							
Bi-Weekly Premium/Code							
Plan Choice:	Employee Only	Emp + Spouse	Emp + Child(ren)	Emp + Family			
<input type="checkbox"/> High Deductible Health Plan	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$150.88	<input type="checkbox"/> \$64.61	<input type="checkbox"/> \$217.35			
<input type="checkbox"/> Base PPO Plan	<input type="checkbox"/> \$56.68	<input type="checkbox"/> \$216.07	<input type="checkbox"/> \$113.36	<input type="checkbox"/> \$312.58			
<input type="checkbox"/> Buy-Up PPO Plan	<input type="checkbox"/> \$103.45	<input type="checkbox"/> \$317.04	<input type="checkbox"/> \$193.95	<input type="checkbox"/> \$469.77			
Dental <input type="checkbox"/> Yes, I wish to change my dental coverage. <input type="checkbox"/> No, I do not wish to change my dental coverage. <input type="checkbox"/> Waive Coverage							
(Select ONE Dollar Amount) Note: All deductions are made on a Pre-Tax basis							
BiWeekly Premium/Code							
Plan Choice:	Employee Only	Emp+ Spouse	Emp + Child(ren)	Emp + Family			
<input type="checkbox"/> HUMANA PPO Low Plan (NO ortho)	<input type="checkbox"/> \$11.75	<input type="checkbox"/> \$23.49	<input type="checkbox"/> \$26.43	<input type="checkbox"/> \$40.53			
<input type="checkbox"/> HUMANA PPO High Plan (inc ortho)	<input type="checkbox"/> \$17.00	<input type="checkbox"/> \$33.99	<input type="checkbox"/> \$42.88	<input type="checkbox"/> \$64.28			
Vision <input type="checkbox"/> Yes, I wish to change my vision coverage. <input type="checkbox"/> No, I do not wish to change my vision coverage. <input type="checkbox"/> Waive Coverage							
(Select ONE Dollar Amount) Note: All deductions are made on a Pre-Tax basis							
BiWeekly Premium/Code							
Plan Choice:	Employee Only	Emp + Spouse	Emp + Child(ren)	Emp + Family			
<input type="checkbox"/> HUMANA Vision	<input type="checkbox"/> \$3.19	<input type="checkbox"/> \$6.37	<input type="checkbox"/> \$6.06	<input type="checkbox"/> \$9.52			

Subtotal amount to be deducted Semi-Monthly:

Last name, first name, middle initial (print)

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

<input type="checkbox"/>	Yes, I wish to elect a dependent care Flexible Spending Account (FSA) with as semi monthly contribution of : (\$7,500 <u>annual</u> limit/single or married if filing jointly or \$3,750 if married filing separately).	\$ _____ (DCB) ^ total/annual amount
<input type="checkbox"/>	Decline dependent care flexible spending account.	
<input type="checkbox"/>	Yes, I wish to elect a medical Flexible Spending Account (FSA) with an ANNUAL contribution of: (\$3,400 annual limit). Do not choose this option if you enroll in the High Deductible Health Plan (HDHP). (Amount is divided by the pay periods/year).	\$ _____ (SAB) ^ total/annual amount
<input type="checkbox"/>	Decline medical care flexible spending account.	
<input type="checkbox"/>	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 \$37.50-single or \$75.00-employee+dependent on a semi-monthly contribution if you choose to elect the HDHP/High Deductible Health Plan.	\$ _____ (EHB1)
<input type="checkbox"/>	In addition to what Southwestern University contributes to my HSA, I elect a semi-monthly contribution of: (not to exceed the annual maximum of \$4,400 for employee only = max \$3,500 employee contribution; or \$8,750 employee + dependent = max \$6,950 employee contribution). A \$1,000 catch up contribution is available for employee age 55 and over.	\$ _____ (HIB) ^ amount each paycheck
<input type="checkbox"/>	I do NOT wish to contribute into my Health Savings Account.	

Term Life / AD&D Election and Optional Dependent Life Coverage Effective ____/____/ 2026

<input type="checkbox"/>	Yes, I wish to elect TERM LIFE / AD&D Employee Coverage for 2 times my annual salary :
	Salary _____ x2 = _____ Rounded Amt _____ /1000= _____ x.067= _____ /2=(_____ x12)/26= _____ Apx BiWkly Prem
<input type="checkbox"/>	I Waive Term Life / AD&D Employee Coverage

Optional Life Dependent Coverage Note: you must elect Term Life (above) in order to elect Dependent Coverage

<input type="checkbox"/>	Yes, I wish to elect Optional Dependent Life Coverage
<input type="checkbox"/>	Option One: \$2.68 BiWeekly = \$25,000(sps)/\$10,000(child) of coverage
<input type="checkbox"/>	Option Two: \$1.11 BiWeekly = \$10,000(sps)/\$5,000(child) of coverage
<input type="checkbox"/>	I Waive Term Life / AD&D Employee Coverage

Total amount to be deducted SEMI-MONTHLY:**Retirement Plan - TIAA/CREF Regular Retirement Plan 403(b)**

<input type="checkbox"/>	Not Eligible until after one year waiting period: Effective Date of Coverage: _____
<input type="checkbox"/>	Eligible as of : _____
<input type="checkbox"/>	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	<input type="checkbox"/> A <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F			N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life
Child	<input type="checkbox"/> A <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life
Child	<input type="checkbox"/> A <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life
Child	<input type="checkbox"/> A <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life

continue on other side if more space is needed

Last name, first name, middle initial (print)

<p>Authorization - Includes important HSA and FSA information</p> <ul style="list-style-type: none">• 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 WEX / 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 "<u>Change in Family Status</u>" as defined by the Internal Revenue Code.• The Southwestern University plan year runs from January 1, 2026 through December 31, 2026. The grace period for incurring Health Care and Dependent Care Flexible Spending Account expenses has been extended to March 15, 2027. The deadline for filing all claims will be April 30, 2027.• The unused balance of the Flexible Spending Accounts is <u>forfeited</u> if unclaimed by April 30, 2027. I understand that if my employment terminates prior to March 15, 2027, 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 \$3,750 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