INDIANA UNIVERSITY

2024 Benefits Open Enrollment Form

SECTION 1—PARTICIPANT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**
10-digit University ID:	**Date of Birth:**	
Campus: ☐ Bloomington ☐ East ☐ Fort Wayne ☐ IUPUI ☐ Kokomo ☐ Northwest ☐ Southeast ☐ South Bend		
Contact Phone:	**Contact Email:**	

SECTION 2—MEDICAL COVERAGE

Check all options that apply.

- ☐ **No changes**
- ☐ **Add** medical coverage
- ☐ **Add child(ren)** to medical
- ☐ **Add spouse** to medical
- ☐ **Change** from one medical plan to another
- ☐ **Drop** medical coverage
- ☐ **Drop child(ren)** from medical
- ☐ **Drop spouse** from medical

Check the box associated with your selected medical plan and level of coverage. Check one option only.

Anthem PPO HDHP

- ☐ Employee Only (80)
- ☐ Employee w/Child(ren) (82)
- ☐ Employee w/Spouse (81)
- ☐ Family (83)

Anthem PPO $500 Deductible

- ☐ Employee Only (70)
- ☐ Employee w/Child(ren) (72)
- ☐ Employee w/Spouse (71)
- ☐ Family (73)

SECTION 3—TOBACCO-FREE AFFIDAVIT

For IU employees and spouses enrolled in an IU-sponsored medical plan only.

I am making this affirmation to receive the 2024 medical premium reduction for non-use of tobacco ($15 employee or spouse/$30 for both). I understand that if I, or my spouse, begin routine use of tobacco during the year, I am no longer eligible for the premium reduction and must report this change to Human Resources immediately. I understand that tobacco includes all forms of tobacco products that are smoked (e.g., cigarettes, cigars, pipes, electronic cigarettes, vapes), applied to the gums (e.g., dipping, chewing tobacco, or snuff), and/or inhaled. I understand that intentional falsification of this affidavit or failure to report the commencement of tobacco use after completing this affidavit can constitute fraud.

Employee (initial one):

_____ I do not currently use any tobacco products and agree not to during the 2024 plan year.

_____ I decline to respond.

Spouse enrolled on your IU medical plan (initial one):

_____ My spouse does not currently use any tobacco products and agrees not to during the 2024 plan year.

_____ I decline to respond.

SECTION 4—HEALTH SAVINGS ACCOUNT (for HDHP participants only)

If you wish to enroll in the Health Savings Account (HSA), enter your annual contribution election below. Your annual contribution must be between the minimum ($300) and the maximum listed in the table below. By entering an annual contribution election below you certify that you meet the eligibility requirements for an HSA; authorize the plan administrator, Nyhart, an Acensus company, to open an HSA in my name with WEX Inc.; and agree to the **Custodial Agreement**, **Electronic Disclosure Statement**, **Patriot Act Requirements**, **IU Benefit Card Terms and Conditions**, and to **Nyhart's banking fees**. available on request from IU Human Resources.

Contribution Limits

Limits can be affected by a spouse's HSA contributions, Archer MSA contributions, and/or the number of months you are covered under an HDHP.

	IRS maximum annual contribution limit	IU's annual contribution to your HSA	The most you can contribute to your HSA in 2024	The most you can contribute to your HSA in 2024 if you're age 55+
Employee-only	$4,150	$1,300	**$2,850**	$3,850
All other coverage levels	$8,300	$2,600	**$5,700**	$6,700

Eligibility

To be eligible for an HSA, you must meet the following requirements: (1) You must be covered under a high deductible health plan (HDHP); (2) You have a valid SSN; (3) You are not listed as a dependent on someone else's tax return; (4) You are not enrolled in a federal government plan such as Medicare or Tricare (if you have VA benefits, receiving preventive care services or treatment for a service-related disability from the VA does not disqualify an individual from participating in an HSA); and (5) You have no other medical coverage.

☐ **Enroll** Annual contribution election: $_____ ☐ **Waive**

Continued on next page.

Name:	10-digit ID:

SECTION 5—DENTAL COVERAGE

Check all options that apply.

- ☐ **No changes**
- ☐ **Add** dental coverage
- ☐ **Add child(ren)** to dental
- ☐ **Add spouse** to dental
- ☐ **Drop** dental coverage
- ☐ **Drop child(ren)** from dental
- ☐ **Drop spouse** from dental

Check the box associated with your selected dental plan and level of coverage. Check one option only.

IU Dental Plan

- ☐ Employee Only (5)
- ☐ Employee w/Child(ren) (7)
- ☐ Employee w/Spouse (6)
- ☐ Family (8)

SECTION 6—DEPENDENT INFORMATION FOR MEDICAL/DENTAL COVERAGE

If you indicated any changes to your medical or dental coverage, complete this section by listing ALL covered dependents (spouse and/or children) that you wish to have enrolled in coverage in 2023. Attach required documentation (e.g. marriage or birth certificate) to this form.

Full Legal Name*	Relationship to You*	Date of Birth* (mm/dd/yyyy)	Sex*	SSN	Enroll in Medical?*	Enroll in Dental?*

**Required information*

SECTION 7—FLEXIBLE SPENDING ACCOUNTS

FSA re-enrollment is required each year to participate. List your annual contribution election, not the per paycheck amount.

Healthcare FSA

- ☐ **Waive**
- ☐ **Enroll** Annual contribution election: $_____

(Maximum is $3,050 per employee)

Dependent Care FSA

- ☐ **Waive**
- ☐ **Enroll** Annual contribution election: $_____

(Maximum is $5,000 per household or $2,500 each for married employees who file their income taxes separately)

SECTION 8—CRITICAL ILLNESS INSURANCE

Check all options that apply. Coverage may be elected for you and your spouse. When you elect employee coverage, your eligible children through age 25 are automatically enrolled with no additional cost and no requirement to submit their enrollment details.

- ☐ **Add employee** coverage (this option includes coverage for your eligible children with no additional cost)
- ☐ **Add spouse** coverage
- ☐ **Waive** coverage

Check the box associated with your selected coverage options and benefit amounts. Check one option for employee and one option for spouse only.

Employee Coverage

- ☐ $10,000
- ☐ $20,000
- ☐ $30,000
- ☐ $40,000
- ☐ $50,000

Spouse Coverage (cannot exceed 50% of employee coverage)

- ☐ $5,000
- ☐ $10,000
- ☐ $15,000
- ☐ $20,000
- ☐ $25,000

Complete this section only if you wish to enroll your spouse.

Spouse Last Name:	Spouse First Name:	Spouse Middle Initial:
Spouse Date of Birth:	**Spouse Gender:** ☐ Male ☐ Female ☐ Other/Undefined	

Continued on next page.

Name:	10-digit ID:

SECTION 9—SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Check all options that apply.

- ☐ **No changes**
- ☐ **Add** coverage
- ☐ **Drop** coverage
- ☐ **Change** individual/family level
- ☐ **Change** coverage amount
- ☐ **Change** beneficiaries

Check the box associated with your selected coverage option and benefit amount. Check one option only.

Employee Only Coverage

- ☐ $30,000 (10)
- ☐ $60,000 (11)
- ☐ $90,000 (12)
- ☐ $120,000 (13)
- ☐ $180,000 (14)
- ☐ $240,000 (15)
- ☐ $300,000 (16)
- ☐ $350,000 (17)
- ☐ $400,000 (18)
- ☐ $450,000 (19)
- ☐ $500,000 (20)

Family Coverage

- ☐ $30,000 (21)
- ☐ $60,000 (22)
- ☐ $90,000 (23)
- ☐ $120,000 (24)
- ☐ $180,000 (25)
- ☐ $240,000 (26)
- ☐ $300,000 (27)
- ☐ $350,000 (28)
- ☐ $400,000 (29)
- ☐ $450,000 (30)
- ☐ $500,000 (31)

Complete this section only if you wish to change your beneficiaries. Benefit percentages must total 100% and must be whole numbers.

Primary Beneficiary(ies):

Full Legal Name	Birth Date or Trust Date	Address	Relationship	Last Four Digits of SSN	% of Benefit
				XXX-XX-	
				XXX-XX-	

=100%

Contingent Beneficiary(ies):

Full Legal Name	Birth Date or Trust Date	Address	Relationship	Last Four Digits of SSN	% of Benefit
				XXX-XX-	
				XXX-XX-	

=100%

SECTION 10—EMPLOYEE CERTIFICATION

1. I request membership for myself and my dependent(s) in the plans I have elected on this form. I authorize IU to withhold my contributions for these plans from my pay.
2. I have read and understand the university's plan eligibility requirements; the dependents listed on this form meet all eligibility requirements. I understand my duty to notify the university within 30 days of any changes that affect the eligibility of any of my covered dependents; for example, marriage or divorce. I understand that enrolling a dependent who is not eligible, or failing to provide notice of ineligibility, can result in retroactive termination of health plan coverage for me and my dependents. I also understand that coverage of an ineligible dependent will result in liability on my part for costs paid by the plan while my dependent was ineligible.
3. I understand that the plan may use my personal health information for the purposes of treatment, payment, and health care operations, and other uses as outlined in the plan's privacy notice, and consistent with federal HIPAA regulations.
4. The information supplied on this form is true and complete. I understand that any intentional false information or statements will be grounds for IU to void my coverage and/or terminate my employment.

Signature:	Date:

Make a copy of this form for your records.

Submit completed form to IU Human Resources at askhr@iu.edu; fax to (812) 855-3409;
or mail to IU Human Resources, ATTN: Open Enrollment, 2709 E 10th Street, Suite 321, Bloomington, IN 47408