INDIANA UNIVERSITY

2025 IU Resident Benefits Open Enrollment Form

SECTION 1—PARTICIPANT INFORMATION

Last Name:	First Name:	Middle Initial:
10-digit University ID:	Date of Birth:	
Contact Phone:	Contact Email:	
Home Address Street:		
Home Address City:	Home Address State:	Home Address Zip:

SECTION 2—MEDICAL COVERAGE

Check all options that apply.

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

Check the box associated with the level of coverage you wish to elect in 2025. Check one option only.

Anthem IU Resident PPO Plan

- ☐ Resident Only
- ☐ Resident w/Child(ren)
- ☐ Resident w/Spouse
- ☐ Family

SECTION 3—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 the level of coverage you wish to elect in 2025. Check one option only.

Cigna Dental Plan

- ☐ Resident only
- ☐ Resident w/child(ren)
- ☐ Resident w/spouse
- ☐ Family

SECTION 4—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 2025. 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*

Continued on next page.

Name:	10-digit ID:

SECTION 5—FLEXIBLE SPENDING ACCOUNTS

FSA re-enrollment is required each year to participate. List your annual contribution election for 2025 below, not the per paycheck amount.

Healthcare FSA

☐ **Waive**
☐ **Enroll** Annual contribution election: $_____
(Maximum is $3,200 per employee)

Dependent care FSA

☐ **Waive**
☐ **Enroll** Annual contribution election: $_____
(Maximum is $5,000 per household)

SECTION 7—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 for 2025. 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 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.

☐ **No changes**
☐ **Add** employee coverage
☐ **Change** employee coverage level
☐ **Drop** employee coverage
☐ **Add** spouse coverage
☐ **Change** spouse coverage level
☐ **Drop** spouse coverage

Check the box(es) associated with the level of coverage and benefit amount you wish to elect in 2025.

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 8—RESIDENT 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**