INDIANA UNIVERSITY

2025 Employee Benefits Open Enrollment Form

SECTION 1—PARTICIPANT INFORMATION

Last name:	**First name:**	**Middle initial:**
10-digit university ID:	**Date of birth:**	

Campus: ☐ Bloomington ☐ Indianapolis ☐ East ☐ Fort Wayne ☐ 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 the medical plan and level of coverage you wish to elect in 2025. 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 medical plan participants only)

I am making this affirmation to receive the 2025 medical premium reduction for non-use of tobacco ($7.50 employee or spouse/$15 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 2025 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 2025 plan year.

_____ I decline to respond.

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

By electing this benefit, you certify that you meet the following IRS-defined eligibility requirements for an HSA under IRC §223:

- you are covered under a qualified high deductible health plan (including the Anthem PPO HDHP),
- you have a valid social security number,
- you are not listed as a dependent on anyone's tax return,
- you do not have medical coverage other than a qualified HDHP, and
- you are not enrolled in Medicare (enrollment in any part of Medicare makes you ineligible to make or receive tax-free HSA contributions).

You also authorize the plan vendor, WEX, to open an HSA in your name and agree to the Custodial Agreement and Disclosure Statement, Electronic Disclosure, Important Information on Patriot Act Requirements, IU Benefit Card Terms and Conditions, and to the Schedule of Fees.

If you're under age 55...	IRS limit:	IU contributes:	You can contribute up to:
Employee-only coverage	$4,300	$1,300	**$3,000**
All other coverage levels	$8,550	$2,600	**$5,950**

If you're age 55 & older...	IRS limit:	IU contributes:	You can contribute up to:	Plus the $1,000 catch-up, for a total of:
Employee-only coverage	$4,300	$1,300	$3,000	**$4,000**
All other coverage levels	$8,550	$2,600	$5,950	**$6,950**

Enter your annual contribution election below. Your annual contribution must be between $300 and the maximum listed in the table above.

☐ **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 spouse** from dental
- ☐ **Drop child(ren)** from dental

Check the box associated with the level of coverage you wish to elect in 2025. 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 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*

SECTION 7—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 or $2,500 each for married employees who file their income taxes separately)

SECTION 8—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 the level of coverage and benefit amount you wish to elect in 2025. 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)

Add/update your Supplemental AD&D beneficiaries on the next page.

Continued on next page.

Name:	10-digit ID:

Complete this section only if you wish to change your Supplemental AD&D beneficiaries for 2025. Percents must total 100% and 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-	
				XXX-XX-	
				XXX-XX-	

=100%

Contingent ("Secondary") Beneficiary(ies):

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

SECTION 9—LONG-TERM DISABILITY INSURANCE

Check all options that apply. Outside of this special enrollment period, LTD enrollment or coverage increases will require you to go through medical underwriting (provide proof of good health). If you have previously applied for LTD and been denied, you are unable to enroll during this period.

- ☐ **No changes**
- ☐ **Add** coverage
- ☐ **Increase** coverage
- ☐ **Decrease** coverage
- ☐ **Drop** coverage

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

90-Day Benefit Waiting Period

- ☐ Without Annuity Contribution Benefit
- ☐ With Annuity Contribution Benefit

180-Day Benefit Waiting Period

- ☐ Without Annuity Contribution Benefit
- ☐ With Annuity Contribution Benefit

Continued on next page.

Name:	10-digit ID:

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 all four pages of this 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