Southwestern University

2013 Flexible Benefits Enrollment Form

Plan Year January 1, 2013 - December 31, 2013

I. PARTICIPANT INFORMATION

Name _____ Social Security # **XXX-XX-**

Address _____ Pay Cycle: 12

☐ New Address (circle one) 9

City_____State_____Zip_____ Eligibility Date: **1/1/2013** 26

II. SOUTHWESTERN UNIVERSITY CONTRIBUTION FOR MEDICAL INSURANCE

$6204.00-Annual; $517.00-12 month; $689.33-9 month faculty; $517.00-9 months of benefits; $238.62-Bi-weekly

III. SECTION 125 ELECTIONS

Pay Cycle	12 month	9 month (Faculty paid over 9 months)	9 month (1st Year Visiting Faculty)	bi-weekly (26 pay periods)	Enter your selection amount
# Months of Benefits Coverage	12	12	9	12	
A. Medical Insurance ☐ I DO ☐ I do NOT elect to pre-tax Medical premiums.					
Basic Plan - PPO					
Employee only	362.00	482.67	362.00	167.08	
Employee + spouse	634.00	845.33	634.00	292.62	
Employee + child(ren)	543.00	724.00	543.00	250.62	
Employee + family	822.00	1,096.00	822.00	379.38	
B. **Total Medical Premium**					
C. **SU Contribution**	12 month……...……..up to $517.00 9 month faculty……up to $689.33 9 months of benefits ...……..……...up to $517.00 Bi-weekly……...up to $238.62				
D. **Your Sub-total Medical Insurance Benefit Cost** (subtract C from B)					

Note: SU's contribution is for the purchase of medical insurance only.

Dental and Vision Insurance are optional. Employees are responsible for paying the full premium.

E. Dental Plan ☐ I DO ☐ I do NOT elect to pre-tax Dental premiums.					
DentalGuard Indemnity					
Employee only	43.08	57.44	43.08	19.88	
Employee + spouse	74.13	98.84	74.13	34.21	
Employee + child(ren)	72.16	96.21	72.16	33.30	
Employee + family	112.37	149.83	112.37	51.86	
Managed DentalGuard					
Employee only	12.22	16.29	12.22	5.64	
Employee + spouse	19.67	26.23	19.67	9.08	
Employee + child(ren)	23.59	31.45	23.59	10.89	
Employee + family	30.94	41.25	30.94	14.28	
F. **Vision Plan** ☐ I DO ☐ I do NOT elect to pre-tax Vision premiums.					
Employee only	7.09	9.45	7.09	3.27	
Employee + spouse	11.73	15.64	11.73	5.41	
Employee + child(ren)	12.23	16.31	12.23	5.64	
Employee + family	16.94	22.59	16.94	7.82	
G. **Sub-total Insurance Benefits Selected** (add E and F)					
H. **Insert Medical Insurance Total from Line D**					
I. **Your Total Health Insurance Benefit Cost** (add G and H)					

	Per Pay Period Amount	Annual Amount
J. **DEPENDENT CARE** (not to exceed the lesser of $5,000; your salary; your spouse's salary; or your actual expenses.)		
K. **HEALTH CARE REIMBURSEMENT** (not to exceed $2,500 per plan year)		

I understand that if I elect to participate, any insurance benefit premium (as indicated above), deferred from my paycheck will be made on a pre-tax basis (also commonly referred to as “before-tax basis”), otherwise the deferrals will be made on a post-tax basis (referred to as “after-tax basis”).

IV. AUTHORIZATION

My signature below signifies that I have read and understand the following:

* 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. The salary reductions will be made in substantially equal amounts, to the extent administratively feasible. I further authorize Boon-Chapman, Inc. 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).
* My elections, 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, 2013 through December 31, 2013. The grace period for incurring Health Care and Dependent Care expenses has been extended to March 15, 2014. The deadline for filing all claims will be April 30, 2014.
*The unused balance of the flexible spending accounts are forfeited if unclaimed by April 30, 2014 or 45 days following my termination date.
* I hereby verify that, if I have elected salary reduction contributions for the Dependent Care benefit in the amounts which will exceed the $2,500 in one calendar year, and if I am married, 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.

Employee Signature Date