

WILKES UNIVERSITY

FLEXIBLE BENEFITS WORKSHEET

JUNE 1, 2011 TO MAY 31, 2012

Name:	Social Security Number:
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PLEASE PROVIDE THE FOLLOWING INFORMATION FOR ALL DEPENDENTS YOU COVER UNDER THE MEDICAL, DENTAL AND VISION PLANS.

	Name	Sex	Social Security Number	Date Of Birth	Coverage (Select All That Apply)
Spouse					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All
Child					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All
Child					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All
Child					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All
Child					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All

Please complete this section by placing the per pay contribution on the appropriate, corresponding line.

(All Costs Shown Are Semi-Monthly Costs)

A. MEDICAL INSURANCE

A. \$ _____

	BLUE CARE© PPO (300)	BLUE CARE© HMO	BLUE CARE© PPO (1000)
Single	<input type="checkbox"/> \$154.48	<input type="checkbox"/> \$149.55	<input type="checkbox"/> \$125.63
Parent & Child	<input type="checkbox"/> \$267.25	<input type="checkbox"/> \$258.71	<input type="checkbox"/> \$217.35
Parent & Children	<input type="checkbox"/> \$310.52	<input type="checkbox"/> \$300.59	<input type="checkbox"/> \$252.41
Husband & Wife	<input type="checkbox"/> \$361.47	<input type="checkbox"/> \$349.92	<input type="checkbox"/> \$294.00
Family	<input type="checkbox"/> \$397.00	<input type="checkbox"/> \$384.32	<input type="checkbox"/> \$322.90
Waive Coverage *	<input type="checkbox"/> \$0.00		

* If you elect to waive Medical Insurance, you must provide proof of other medical coverage in order to receive the monies available from the Total Compensation Budget. Please attach a copy of proof of insurance to this form or stop by the Human Resources Development Office with original documentation.

B. DENTAL INSURANCE

B. \$ _____

	CONCORDIA FLEX	
	BASIC	ENHANCED
Single	<input type="checkbox"/> \$10.63	<input type="checkbox"/> \$15.58
Family	<input type="checkbox"/> \$28.55	<input type="checkbox"/> \$41.74
Waive Coverage	<input type="checkbox"/> \$0.00	

C. VISION INSURANCE**C. \$** _____

	OPTICHOICE
Single	<input type="checkbox"/> \$3.30
Family	<input type="checkbox"/> \$8.59
Waive Coverage	<input type="checkbox"/> \$0.00

D. VOLUNTARY TERM LIFE INSURANCE**D. \$** _____

Refer To The Voluntary Term Life Insurance Cost Sheet To Calculate Premium/Actual Deductions May Vary Due To Rounding

	BENEFIT	COST
<input type="checkbox"/> Employee	\$ _____	\$ _____
<input type="checkbox"/> Spouse	\$ _____	\$ _____
<input type="checkbox"/> Dependent Child(ren)	\$ _____	\$ _____
<input type="checkbox"/> Waive		

E. VOLUNTARY AD&D INSURANCE**E. \$** _____

Refer To The Voluntary AD&D Insurance Cost Sheet To Calculate Premium/Actual Deductions May Vary Due To Rounding

	BENEFIT	COST
<input type="checkbox"/> Employee	\$ _____	\$ _____
<input type="checkbox"/> Spouse	\$ _____	\$ _____
<input type="checkbox"/> Dependent Child(ren)	\$ _____	\$ _____
<input type="checkbox"/> Waive		

F. MEDICAL SPENDING ACCOUNT**F. \$** _____

- Elect Place Your Semi-Monthly Contribution On Line F.
 Waive

G. DEPENDENT CARE SPENDING ACCOUNT**G. \$** _____

- Elect Place Your Semi-Monthly Contribution On Line G.
 Waive

H. TOTAL COST OF BENEFIT CHOICES (Add A. Through G.)**H. \$** _____**I. BUDGET****I. \$ 112.50** _____**J. NET BALANCE (Compare I. & J.)****J. \$** _____

If H. is greater than I., J. is your semi-monthly contribution.
 If H. is less than I., J. is paid to you as taxable cash.

K. SIGNATURE

I understand that certain benefits require insurance applications and/or health statements and if I do not complete the required forms, I will not be covered for those benefits. I understand that certain amounts of Voluntary Term Life Insurance may require insurance carrier approval. I agree to the salary reductions shown on this worksheet to fund my Benefit Elections on a pre-tax or after-tax basis.

Signature: _____

Date: _____