

# WILKES UNIVERSITY

## FLEXIBLE BENEFITS WORKSHEET

### 2009 - 2010 PLAN YEAR

Name:	Social Security Number:
-------	-------------------------

**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 <sup>®</sup> PPO	BLUE CARE <sup>®</sup> HMO	BLUE CARE <sup>®</sup> HMO PLUS
Single	<input type="checkbox"/> \$121.27	<input type="checkbox"/> \$123.18	<input type="checkbox"/> \$139.73
Parent & Child	<input type="checkbox"/> \$209.80	<input type="checkbox"/> \$213.10	<input type="checkbox"/> \$241.75
Parent & Children	<input type="checkbox"/> \$243.66	<input type="checkbox"/> \$247.48	<input type="checkbox"/> \$280.75
Husband & Wife	<input type="checkbox"/> \$283.80	<input type="checkbox"/> \$288.25	<input type="checkbox"/> \$327.01
Family	<input type="checkbox"/> \$311.69	<input type="checkbox"/> \$316.59	<input type="checkbox"/> \$359.15
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"/> \$ 9.50	<input type="checkbox"/> \$13.92
Family	<input type="checkbox"/> \$25.49	<input type="checkbox"/> \$37.27
Waive Coverage	<input type="checkbox"/> \$0.00	

**C. VISION INSURANCE****C. \$** \_\_\_\_\_

	DAVIS
Single	<input type="checkbox"/> \$2.95
Family	<input type="checkbox"/> \$7.67
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&amp;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. PREPAID LEGAL****H. \$** \_\_\_\_\_

- Elect                                      \$3.75 Semi-Monthly Cost / Zip Code: \_\_\_\_\_  
 Waive

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

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

**L. 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: \_\_\_\_\_

