# 2021 Benefits Enrollment Form

| EMPLOYEE'S LEGAL LAST NAME | LEGAL FIRST NAME | M.I. | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|
| | | | | |

| STREET ADDRESS/APT. NO. | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| EMPLOYEE'S TELEPHONE | BIOLOGICAL SEX | GENDER IDENTITY | MARITAL STATUS |
|---|---|---|---|
| | ☐ MALE<br>☐ FEMALE | _____ | ☐ SINGLE ☐ MARRIED<br>☐ DOMESTIC PARTNER |

## INSURANCE ELECTIONS

**DENTAL COVERAGE:** ☐ EMPLOYEE ☐ EMPLOYEE + CHILD(REN) ☐ EMPLOYEE + SPOUSE/DOMESTIC PARTNER ☐ FAMILY

**MEDICAL PLAN & NETWORK:** ☐ LOW DEDUCTIBLE OPEN ACCESS ☐ HIGH DEDUCTIBLE + HSA OPEN ACCESS ☐ LOW DEDUCTIBLE ACHIEVE ☐ HIGH DEDUCTIBLE + HSA ACHIEVE

**MEDICAL COVERAGE:** ☐ EMPLOYEE ☐ EMPLOYEE + CHILD(REN) ☐ EMPLOYEE + SPOUSE/ DOMESTIC PARTNER ☐ FAMILY

**VISION COVERAGE:** ☐ EMPLOYEE ☐ EMPLOYEE + CHILD(REN) ☐ EMPLOYEE + SPOUSE/ DOMESTIC PARTNER ☐ FAMILY

**I DECLINE:** ☐ DENTAL ☐ MEDICAL ☐ VISION

| First Name & Middle Initial<br>Last Name | Relationship | Sex | Date of Birth<br>Month | Day | Year | Social Security Number | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Do all of the dependent(s) listed above reside at the same address as the employee? ☐ YES ☐ NO

If no, list dependent(s) name and address _____

## FLEXIBLE SPENDING ACCOUNT (FSA)/LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT

**BENEFIT ELECTIONS**

I hereby authorize Augsburg University to reduce my regular compensation to provide for payroll contributions to an FSA. The total annual amount indicated below will be taken equally over the number of FSA eligible payrolls in the calendar year, the maximum number of deductions in the 2021 plan year is 24.

☐ **Medical Care Reimbursement ($2,750 Maximum)** $ _____

☐ **Dependent Care Reimbursement ($5,000 Maximum)** $ _____

## HEALTH SAVINGS ACCOUNT (HSA) ENROLLMENT

**BENEFIT ELECTIONS**

I hereby authorize Augsburg University to reduce my regular compensation to provide for payroll contributions to a HSA. The total amount indicated below will be contributed equally over the number of HSA eligible payrolls in the calendar year, the maximum number of deductions in the 2021 plan year is 24. **If you are 55 or older, you may make additional "catch up" contributions of up to $1,000. If you are enrolled in Medicare Part A – you are not eligible to enroll in an HSA.**

☐ **Single ($3,600 Maximum)** $ _____

☐ **Family ($7,200 Maximum)** $ _____

## BENEFICIARY DESIGNATIONS

Please indicate the name(s) of your primary and secondary beneficiaries:

☐ Life Insurance ☐ Health Savings Account ☐ Flexible Spending Account

**Name:** _____ **Relationship:** _____ **% of proceeds:** _____

**Name:** _____ **Relationship:** _____ **% of proceeds:** _____

☐ Life Insurance ☐ Health Savings Account ☐ Flexible Spending Account

**Name:** _____ **Relationship:** _____ **% of proceeds:** _____

**Name:** _____ **Relationship:** _____ **% of proceeds:** _____

| Employee Signature: | Date: |
|---|---|
| | |