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 ☐ FEMALE	_____	☐ SINGLE ☐ MARRIED ☐ 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 Last Name	Relationship	Sex	Date of Birth 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:

To Submit: Visit augsburg.leapfile.net choose **Secure Upload** > **Augsburg Human Resources. Follow instructions. Attach this file when prompted.**