OPEN ENROLLMENT

HOW TO COMPLETE THE PAPERWORK
2023

BETHEL UNIVERSITY

WHAT YOU NEED

1. Bethel University Enrollment Form
2. Bethel University Benefits Guide 2024
3. Social security numbers for self, spouse, dependents, and/or beneficiaries
4. (optional) pen

Link to Open Enrollment webpages - information and fillable form found here

www.bethel.edu/people-culture/open-enrollment/

1: EMPLOYEE INFORMATION

Benefits Enrollment Form

BETHEL UNIVERSITY

EMPLOYEE INFORMATION – CURRENT (ENTER CHANGE AT BOTTOM)				
First Name: M.I.:	Last Name:		Date of Birth:	
Street Address:	City:	State:	Zip Code:	Hire Date:
Occupation:	Employment Status Full-time Part-time		Social Security Number:	
Home Phone:	Single Married		Gender M	
Work Phone:	Divorced Widowed		F	

special item to note: as you proceed from this point, you **must check either** enroll/elect OR waive/decline every time the form prompts you to

2: MEDICAL PLAN

MEDICAL PLAN				
Medical – HealthPartners (PPO)	Single	Single + 1	Family	Waive
Medical – HealthPartners (HDHP w/HSA)	Single	Single + 1	Family	Waive

Dependent Information Only Complete only if you are enrolling your dependents				
Name	**Gender**	**Relationship**	**Date of Birth**	**Social Security #**

This section must be completed if you or your dependents DO NOT want coverage.
I understand that I am eligible for coverage through my employer. **I DO NOT** want coverage for:

Me and dependents	My spouse	My dependents only

The reason I'm declining coverage at this time is because I or my dependents have coverage provided through:

Spouse's group plan	Individual Policy	MCHA-Dependents Only (dates of coverage)
Medicare	COBRA	Medical Assistance
MinnesotaCare	Other	

Signature of employee: X	Date Signed

(only sign if you are waiving coverage)

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Medical – HealthPartners (PPO)	Single	Single + 1	Family	Waive
Medical – HealthPartners (HDHP w/HSA)	Single	Single + 1	Family	Waive

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Dependent Information Only
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Dependent Information Only
Complete only if you are enrolling your dependents

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I understand that I am eligible for coverage through my employer. **I DO NOT** want coverage for:

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The reason I'm declining coverage at this time is because I or my dependents have coverage provided through:

Spouse's group plan	Individual Policy	MCHA-Dependents Only (dates of coverage)
Medicare	COBRA	Medical Assistance
MinnesotaCare	Other	

Signature of employee: X	Date Signed

(only sign if you are waiving coverage)

3: DENTAL PLAN

DENTAL PLAN				
Dental – Delta Dental	Single	Single + 1	Family	Waive
Dependent Information Only Complete only if you are enrolling your dependents				
Name	**Gender**	**Relationship**	**Date of Birth**	**Social Security #**

special items to note:

- elect (enroll) or waive coverage by placing a check to the right of your selection

3: DENTAL PLAN

DENTAL PLAN				
Dental – Delta Dental	Single	Single + 1	Family	Waive
Dependent Information Only **Complete only if you are enrolling your dependents**				
Name	**Gender**	**Relationship**	**Date of Birth**	**Social Security #**

special items to note:

- be sure to add each dependent that you are enrolling

4: VOLUNTARY VISION COVERAGE

VISION PLAN				
Vision - EyeMed	Single	Single + 1	Family	Waive
Dependent Information Only Complete only if you are enrolling your dependents				
Name	**Gender**	**Relationship**	**Date of Birth**	**Social Security #**

special items to note:

- why would someone want this? Especially since Health Partners covers eye exams?
  - If you end up spending a significant amount on your contacts/eyeglasses each year, you might want to consider this coverage.
- first, select whether you will be ‘electing’ (enrolling) or waiving coverage
- second, identify if you are adding any dependents to your plan

5: FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts (FSA)			
Dependent Care FSA	I elect coverage	I decline coverage	Contribution Amount: $
Health Care FSA	I elect coverage	I decline coverage	Contribution Amount: $
Limited Purpose FSA (if on HSA)	I elect coverage	I decline coverage	Contribution Amount: $

I elect to participate in my employer's Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security Benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement.

special items to note:

- you may elect to have an FSA even if you do not have your medical insurance through Bethel

5: FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts (FSA)			
Dependent Care FSA	I elect coverage	I decline coverage	Contribution Amount: $
Health Care FSA	I elect coverage	I decline coverage	Contribution Amount: $
Limited Purpose FSA (if on HSA)	I elect coverage	I decline coverage	Contribution Amount: $

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Dependent Care FSA = savings to pay for child care

- elect this or decline this
- the contribution amount in the last column is the ANNUAL amount you want put in this FSA
  - $5000 is the maximum annual contribution allowed
    - OR only $2500 if you are married and filing a separate income tax return

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Health Care FSA = savings to pay for health care expenses

- elect this or decline this
- the contribution amount in the last column is the ANNUAL amount you want put in this FSA
  - $ 3,200 is the maximum annual contribution allowed

5: FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts (FSA)			
Dependent Care FSA	I elect coverage	I decline coverage	Contribution Amount: $
Health Care FSA	I elect coverage	I decline coverage	Contribution Amount: $
Limited Purpose FSA (if on HSA)	I elect coverage	I decline coverage	Contribution Amount: $

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Limited Purpose FSA = **Only** people who have selected the **HDHP** Medical plan should fill this out

- elect this or decline this
- the contribution amount in the last column is the ANNUAL amount you want put in this Limited Purpose FSA
  - $ 3200 is the maximum annual contribution allowed
  - one would use this Limited Purpose FSA to pay for Dental and Vision costs

6: HEALTH SAVINGS ACCOUNT (HSA)

Health Savings Account (HSA)			
Health Savings Account	I elect coverage	I decline coverage	Contribution Amount: $

I understand my elected HSA contribution will be deducted from my paycheck until I indicate otherwise. If is my responsibility 1) to determine whether I am eligible to make contributions to my HSA; And 2) to determine whether contributions to this HSA have exceeded the applicable maximum annual contribution limit.

special items to note:

- you will **only fill out this section if you are enrolling in the HDHP** Medical plan
- please elect or decline
- the contribution amount in the last column is the ANNUAL amount you want put in this HSA
  - Maximum annual contribution allowed =
    - $4,150 for single (Bethel contributes $500 of this)
    - $8,300 for single+1 (Bethel contributes $750 of this)
    - $8,300 for family (Bethel contributes $1000 of this)

7: SHORT TERM DISABILITY & LONG TERM DISABILITY

SHORT TERM DISABILITY – The Standard
You are automatically enrolled in the group Short Term Disability.

LONG TERM DISABILITY – The Standard
You are automatically enrolled in the group Long Term Disability.

special items to note:

- There is nothing to do with these sections. You are automatically enrolled.
- There is no cost to you to have these benefits.

8: EMPLOYEE BASIC LIFE BENEFICIARY

Employee Basic Life Beneficiary Designation Form – The Standard			
You are automatically enrolled in the group Basic Life & AD&D Plan.			
Primary Beneficiary(ies)	**Social Security Number**	**Relationship to employee**	**Percent share of proceeds***
1.			
2.			
Secondary Beneficiary(ies)	**Social Security Number**	**Relationship to employee**	**Percent share of proceeds***
1.			
2.			
The beneficiary designation can be changed at any time – the designation takes effect as of the date the completed form is received and accepted by your employer. *The total within each class (Primary and Secondary) must equal 100%			

special items to note:

- All benefits eligible employees receive Basic Life Insurance coverage of 1x annual salary up to $500K
- Additionally, all BE employees receive Accidental Death and Dismemberment coverage equal to your Basic Life coverage IF your death or dismemberment is the result of an accident.
- In this section you are identifying who are your beneficiaries for these Basic plans

9: ADDITIONAL LIFE INSURANCE

Additional Life – The Standard			
Employee only	I elect coverage	I decline coverage	Coverage Amount: $
Spouse coverage**	I elect coverage	I decline coverage	Coverage Amount: $
Child(ren) coverage**	I elect coverage	I decline coverage	Coverage Amount: $

Dependent Information Only Complete only if you are enrolling your dependents			
Name	**Gender**	**Relationship**	**Date of Birth**

*For most plans, "basic annual earnings" is defined as your salary. Basic annual earnings usually exclude bonuses, commissions or overtime. Please see your benefits booklet or check with employer for the exact definition of earnings that applies to you.
**Your spouse and children may only be covered if you are.

About Evidence of Insurability (also known as Proof of Good Health) Evidence of Insurability (EOI) is needed if:

- You apply for higher coverage than the limits described in your benefits booklet.
- You want to increase your existing coverage now (whether your existing coverage is with The Standard or a prior insurance carrier).
- You want to increase your coverage later.
- You decline coverage and then want it later.

If EOI is needed, your coverage will not go into effect until The Standard approves it.

9: ADDITIONAL LIFE INSURANCE

Additional Life – The Standard			
Employee only	I elect coverage	I decline coverage	Coverage Amount: $
Spouse coverage**	I elect coverage	I decline coverage	Coverage Amount: $
Child(ren) coverage**	I elect coverage	I decline coverage	Coverage Amount: $

Dependent Information Only
Complete only if you are enrolling your dependents

Name	Gender	Relationship	Date of Birth

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Employee only	I elect coverage	I decline coverage	Coverage Amount: $
Spouse coverage**	I elect coverage	I decline coverage	Coverage Amount: $
Child(ren) coverage**	I elect coverage	I decline coverage	Coverage Amount: $

Dependent Information Only **Complete only if you are enrolling your dependents**			
Name	**Gender**	**Relationship**	**Date of Birth**

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9: ADDITIONAL LIFE INSURANCE

Additional Life – The Standard			
Employee only	I elect coverage	I decline coverage	Coverage Amount: $
Spouse coverage**	I elect coverage	I decline coverage	Coverage Amount: $
Child(ren) coverage**	I elect coverage	I decline coverage	Coverage Amount: $

Dependent Information Only
Complete only if you are enrolling your dependents

Name	Gender	Relationship	Date of Birth

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- You want to increase your coverage later.
- You decline coverage and then want it later.

If EOI is needed, your coverage will not go into effect until The Standard approves it.

Evidence of Insurability link can be found at: https://myeoi.standard.com/643586

10: ADDITIONAL AD&D

accidental death & dismemberment

Additional AD&D – The Standard		
Employee Only increments of $10,000 to a maximum of $300,000	I elect coverage	Coverage Amount: $
Spouse Only at 50% of the employee AD&D amount	I elect coverage	Coverage Amount: $
Child Only at 15% for each child	I elect coverage	Coverage Amount: $
Spouse and Children at 40% of the employees AD&D coverage amount 10% of the employees AD&D coverage amount for each child.	I elect coverage	Coverage Amount: $

Dependent Information Only Complete only if you are enrolling your dependents			
Name	**Gender**	**Relationship**	**Date of Birth**

special items to note:

- Please meet with Angie Cyrankowski if you have questions about this additional insurance

1: ADDITIONAL LIFE INSURANCE BENEFICIARIES

Additional Life Beneficiary Designation Form – The Standard			
You are automatically enrolled in the group Basic Life & AD&D Plan.			
Primary Beneficiary(ies)	**Social Security Number**	**Relationship to employee**	**Percent share of proceeds***
3.			
4.			
Secondary Beneficiary(ies)	**Social Security Number**	**Relationship to employee**	**Percent share of proceeds***
1.			
2.			
The beneficiary designation can be changed at any time – the designation takes effect as of the date the completed form is received and accepted by your employer. *The total within each class (Primary and Secondary) must equal 100%			

12: CRITICAL ILLNESS INSURANCE

special items to note:

- This is the first of three “Aflac-like” extra coverages you can purchase
- Please elect or decline/waive coverage
- If you want to purchase this, please see the instructions on the bottom.

Critical Illness Insurance – The Standard			
Employee Only	I elect coverage	I decline coverage	Coverage Amount: $
Spouse	I elect coverage	I decline coverage	Coverage Amount: $
Child(ren)	I elect coverage	I decline coverage	Coverage Amount: $

Coverage is age rated. See Benefits guide for rates and more information.

13: ACCIDENT INSURANCE

special items to note:

- This is the second of three “Aflac-like” extra coverages you can purchase
- Please elect or decline/waive coverage
- If you want to purchase this, please see the costs associated in the last column

Accident Insurance – The Standard			
Employee Only	I elect coverage	I decline coverage	$11.43 per month
Employee + Spouse	I elect coverage	I decline coverage	$17.63 per month
Employee + Child(ren)	I elect coverage	I decline coverage	$21.80 per month
Family	I elect coverage	I decline coverage	$34.07 per month

14: HOSPITAL INDEMNITY INSURANCE

special items to note:

- This is the third of three “Aflac-like” extra coverages you can purchase
- Please elect or decline/waive coverage
- If you want to purchase this, please see the costs associated in the last column

Hospital Indemnity Insurance – The Standard			
Employee Only	I elect coverage	I decline coverage	$15.72 per month
Employee + Spouse	I elect coverage	I decline coverage	$26.58 per month
Employee + Child(ren)	I elect coverage	I decline coverage	$22.10 per month
Family	I elect coverage	I decline coverage	$39.48 per month

15: ACKNOWLEDGEMENT & SIGNATURE

I understand that:

- My employer will deduct all or part of the premiums from my pay.
- If I decline coverage for me or my family now and want it later, I/we will have to provide evidence of insurability acceptable to The Standard
- I have read the "About Evidence of Insurability" notice.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.
- If I am not actively out of work due to injury, illness, layoff or leave of absence on the date that any initial or increased Additional Life, Critical Illness, Accidental or Hospital Indemnity coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- If my spouse or any of my dependent children are hospital-confined due to an injury or illness on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer hospital-confined and are able to perform their normal activities.

Acknowledgement and Signature	
Signature of employee:	Date Signed

ENROLLMENT FORM
MUST BE SUBMITTED TO OPC
(IN PAPER OR ELECTRONIC FORMAT)

BY **TUESDAY, NOVEMBER 21**, 2023

16: STILL HAVE QUESTIONS?

Please schedule an individual appointment with Bethel's Benefits Administrator, Angie Cyrankowski.

Here is a link to her appointment calendar

ALL PLAN DOCUMENTS CAN BE FOUND ON THE OPEN ENROLLMENT WEBSITE

BETHEL.EDU/PEOPLE-CULTURE/OPEN-ENROLLMENT