2022 BENEFITS ENROLLMENT FORM

EMPLOYEE INFORMATION

Name: _____ **GWID:** _____

Date of Birth: _____ **Date of Hire:** _____ **Sex:** Male ☐ Female ☐

Street: _____ **City, State:** _____ **Zip code:** _____

Phone Number: _____ **Email:** _____

Employment Status: Full-Time ☐ Part-Time ☐ **Pay Frequency:** Biweekly ☐ Monthly ☐

SELECT QUALIFIED LIFE EVENT (QLE)

Changes are only permitted within 30 calendar days of a Qualified Life Event (QLE). Any changes made as a result of a QLE must be consistent with that event and documentation must be provided along with this enrollment form. Benefit changes will be effective the 1st of the month following receipt of documentation, as long as it is received within 30 calendar days from the QLE date.

Please note: Certain life events permit changes within 60 calendar days, including birth, adoption, legal guardianship, divorce, or becoming eligible for Medicaid or Children's Health Insurance Plan (CHIP). Benefit changes will be effective the 1st of the month following receipt of documentation, as long as it is received within 60 calendar days from the QLE date.

☐ **New Hire/Rehire**
☐ **2022 Open Enrollment**
☐ **Birth/Adoption/Legal Guardianship**
☐ **Participant Loss or Gain of Coverage**
☐ **Spouse/Domestic Partner – Loss/Gain of Coverage**
☐ **Job Status Change (i.e., PT to FT, FT to PT, etc.)**
☐ **Marriage/Newly Eligible Domestic Partner**
☐ **Taking or Returning from a Leave of Absence**
☐ **Other:** _____

DEPENDENT(S) TO BE COVERED:

You may cover your spouse or domestic partner and/or dependent children under the medical, dental and vision plans. Please complete the information below for each individual you wish to cover. Be sure to check applicable plans. This form will not be processed until documentation verifying dependent eligibility is received (e.g., birth certificate, marriage certificate, etc.).

Dependent Name (#1): _____ **DOB** _____ **SSN:** _____
Relationship: Spouse ☐ Domestic Partner ☐ Child ☐
Tax Dependent: Yes ☐ No ☐ **Disabled:** Yes ☐ No ☐
Enroll in: Medical ☐ Dental ☐ Vision ☐

Dependent Name (#2): _____ **DOB** _____ **SSN:** _____
Relationship: Spouse ☐ Domestic Partner ☐ Child ☐
Tax Dependent: Yes ☐ No ☐ **Disabled:** Yes ☐ No ☐
Enroll in: Medical ☐ Dental ☐ Vision ☐

Dependent Name (#3): _____ **DOB** _____ **SSN**: _____
Relationship: Spouse ☐ Domestic Partner ☐ Child ☐
Tax Dependent: Yes ☐ No ☐ **Disabled:** Yes ☐ No ☐
Enroll in: Medical ☐ Dental ☐ Vision ☐

Dependent Name (#4): _____ **DOB** _____ **SSN**: _____
Relationship: Spouse ☐ Domestic Partner ☐ Child ☐
Tax Dependent: Yes ☐ No ☐ **Disabled:** Yes ☐ No ☐
Enroll in: Medical ☐ Dental ☐ Vision ☐

DEPENDENT VERIFICATION

☐ By checking this box, you are confirming that you have read and understood all the plan terms, and you certify that all of the individuals you have requested to enroll (including yourself) are eligible to be covered. Your enrollment of any individual who is not eligible under the terms of the plan may be treated as fraud, resulting in termination of the individual's coverage retroactive to the original enrollment date and the recovery of any claims paid, to the extent allowed by law.

Please review the benefit options presented below and select the benefits that best suit your individual/family needs. Options not clearly designated or left blank will be considered to be waived.

MEDICAL

Please select one option below. If you select coverage other than Employee Only, you must provide dependent information in the Dependent Section of this form.

UnitedHealthcare GW PPO
☐ Employee Only ☐ Employee + Spouse/DP ☐ Employee + Child(ren) ☐ Employee + Family

UnitedHealthcare GW Health Savings Plan (HSP)
☐ Employee Only ☐ Employee + Spouse/DP ☐ Employee + Child(ren) ☐ Employee + Family

Waive Coverage ☐ **Do you have other medical coverage?** ☐ Yes ☐ No

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HEALTH SAVING ACCOUNT (HSA)

(Select ONLY if you selected the UHC GW Health Savings Plan medical plan)

If enrolling in the GW HSP medical plan, you have the option (if you meet the eligibility requirements) to contribute to a tax-free Health Savings account. Details on the benefits of contributing to a Health Savings Account can be found on the Benefits website at https://hr.gwu.edu/hsa.

The IRS annual maximum contribution for 2022 is $3,600 for Employee Only or $7,200 for Employee plus Spouse/Child(ren) or Family coverage. If you are age 55 or older, you can elect $1,000 in catch-up elections (this amount is in addition to the maximums listed above). GW will match your HSA contributions dollar-for-dollar up to $600 for Employee Only HSP coverage, or up to $1,200 if covering dependents under the HSP. Please note: Your contribution + GW Match cannot exceed the IRS annual limit.

Please note: If you enroll in the HSP and do not meet the HSA eligibility requirements, you have the option of enrolling in a Health Care Flexible Spending Account (FSA). Please see HSA Eligibility section below for details.

HSA Annual Contribution: $_____

HEALTH SAVING ACCOUNT (HSA) ELIGIBILITY

Each of the following statements must be true in order to be eligible to elect and contribute to an HSA:

- Must be covered under the Health Savings Plan (HSP)
- Cannot be covered by another non-High Deductible health plan.
- Cannot be enrolled in Medicare or TRICARE
- Cannot be claimed as a dependent on someone else's tax return

Other insurance or accounts not allowed with an HSA:

- Part A and/or Part B Medicare (In some cases, drawing Social Security benefits enrolls you in Medicare Part A)
- TRICARE or TRICARE For Life
- Any VA benefits used within previous 3 months, unless used for a service-connected disability

☐ By checking this box, I verify that **I meet all criteria** for the Health Saving Account as listed above and certify I am eligible to elect the HSA. Please enter your contribution amount directly above.

☐ By checking this box, I verify that **I do not meet all criteria** for the Health Saving Account as listed above and certify that I wish to enroll in the Health Care FSA. Please enter your contribution amount in the Health Care FSA section below, if enrolling.

FLEXIBLE SPENDING ACCOUNTS (FSA)

You may contribute a maximum of $2,750 per year to a Health Care FSA (HCFSA) and a maximum of $5,000 (or $2,500 if you and your spouse file separate tax returns) per year to your Dependent Day Care FSA (DCFSA). There is a $100 contribution minimum for both the Health and Dependent Care FSAs. To take advantage of savings offered through the FSA(s), you must enroll or re-enroll annually.

Important Deadlines for FSA Accounts:

- For 2022, you have until March 15, 2023, to incur eligible healthcare expenses. You have until April 30, 2023 to submit claims for services.
- The March 15th deadline period does not apply to the Dependent Day Care Account. For 2022, you have until December 31, 2022 to incur eligible dependent care expenses. You have until April 30, 2023 to submit claims for services.

Please Note: If you elected the HSP medical plan, you are not eligible to elect the Health Care FSA, unless you do not meet the HSA eligibility requirements. If you elected the HSP medical plan, you are eligible to elect a Dependent Day Care FSA.

Please Note: Your annual Dependent Day Care FSA maximum election amount may be reduced based on the level of participation by all GW faculty and staff.

FSA Health Care Annual Contribution: $_____

FSA Dependent Day Care Annual Contribution: $_____

DENTAL

Please select one option below. You may elect dental coverage even if you do not elect medical coverage. If you select coverage other than Employee Only, you must provide dependent information in the Dependent Section of this form.

Aetna High PPO
☐ Employee Only ☐ Employee + One ☐ Employee + Family

Aetna Low PPO
☐ Employee Only ☐ Employee + One ☐ Employee + Family

Aetna DMO
☐ Employee Only ☐ Employee + One ☐ Employee + Family

Waive Coverage ☐

VISION

Please select one option below. You may elect vision coverage even if you do not elect medical coverage. If you select coverage other than Employee Only, you must provide dependent information in the Dependent Section of this form.

UnitedHealthcare Basic Vision
☐ Employee Only ☐ Employee + One ☐ Employee + Family

UnitedHealthcare Enhanced Vision
☐ Employee Only ☐ Employee + One ☐ Employee + Family

Waive Coverage ☐

VOLUNTARY SHORT-TERM DISABILITY (EMPLOYEE PAID)

If you are a full-time employee with less than two years of benefits-eligible service or part-time employee or a Resident, you are eligible to elect the Voluntary Short-Term Disability (VSTD) plan. Please select one of the boxes below.

Please Note: If you are enrolling outside of your initial enrollment period, you may need to complete Evidence of Insurability (EOI). If applicable, you will receive information on how to submit your EOI from Benefits via your GW email. Your election will be in a pending status until your EOI is processed by Lincoln Financial. Please visit hr.gwu.edu/EOI for further details.

Elect VSTD ☐ Waive Coverage ☐

GROUP BASIC LIFE AND AD&D INSURANCE

Group Basic Life and Basic AD&D are both equal to one times your annual benefits salary, up to the plan maximum ($500,000) and are both subject to age reduction. The university pays for your Basic Life and AD&D coverage. The cost of any Basic Life coverage exceeding $50,000 is considered "imputed income" by the IRS which will be reported on your W-2 form as part of your taxable income. **If you wish to avoid imputed income by capping your Basic Life insurance, please check here: ☐**

Please Note: If at a later eligibility opportunity, you would like to uncap your Basic Life, you may be required to submit Evidence of Insurability (EOI).

OPTIONAL LIFE AND AD&D INSURANCE

You can purchase optional life and AD&D coverage for yourself and your eligible dependents. Optional Life and AD&D coverage is 100 percent employee-paid. You must elect Optional Life and AD&D Insurance for yourself in order to elect it for your spouse, domestic partner, or children. Optional Spouse/Domestic Partner Life and AD&D coverage is limited to 50% of the amount you elect for yourself. Optional Child Life and AD&D coverage is limited to $20,000 or 50% of Optional Employee Life/AD&D (whichever is less). *If you select coverage other than Employee Only, you must provide dependent information in the Dependent Section of this form.*
Optional Employee Life Insurance: You may purchase Optional Group Term Life Insurance in increments of $10,000. The maximum amount of coverage is $1,000,000. If electing during your initial enrollment period or after a **qualifying** family status change (e.g., birth, marriage, divorce, etc.), you may elect up to $500,000 without providing Evidence of Insurability (EOI).If electing during Open Enrollment, you may elect up to an additional $250,000, up to a maximum of $500,000, without EOI. Please visit hr.gwu.edu/EOI for further details.

Employee Coverage Amount $_____ (in increments of $10,000 maximum of $1,000,000)

Optional Dependent Life Insurance:

Spouse, Coverage Amount $_____ (in increments of $5,000, maximum of $500,000)

Domestic Partner, Coverage Amount $_____ (in increments of $5,000, maximum of $500,000)

Child(ren), Coverage Amount $_____ (in increments of $2,000, maximum of $20,000)

Optional Employee AD&D Insurance: You may purchase Optional AD&D Group Term Life Insurance in increments of $10,000. The maximum amount of coverage is $1,000,000. You do not have to elect Optional Employee Life Insurance in order to purchase Optional Employee AD&D Insurance.

Employee Coverage Amount $_____ (in increments of $10,000 maximum of $1,000,000)

Optional Dependent AD&D Insurance:

Spouse, Coverage Amount $_____ (in increments of $5,000, maximum of $500,000)

Domestic Partner, Coverage Amount $_____ (in increments of $5,000, maximum of $500,000)

Child(ren), Coverage Amount $_____ (in increments of $2,000, maximum of $20,000)

IMPORTANT: If you are enrolling in Optional Life Insurance to a level requiring Evidence of Insurability (EOI), you will receive information on how to submit your EOI from Benefits via your GW email. Your election will be in a pending status until your EOI is processed by Lincoln Financial. No EOI is required for Optional AD&D Insurance.

LONG-TERM DISABILITY INSURANCE BUY UP OPTION

(Full- time employees eligible only)

After one year of employment, all full-time faculty and staff receive Basic Long-Term Disability (LTD) insurance. (The one-year waiting period may be waived based on prior employer coverage. Please visit the Benefits website at https://hr.gwu.edu/long-term-disability-insurance for further details.) Full-time employees have the option to elect a higher level of LTD coverage. This option provides you with 66.67 percent of your monthly benefits salary, up to a maximum of $12,000 per month, after 180 days of disability.

Elect LTD Buy-up ☐ **Waive Coverage ☐**

LEGAL RESOURCES

The group legal program, provided by Legal Resources®, provides a variety of legal services (e.g., real estate, consumer disputes, credit problems, wills, etc.). The legal plan has a mandatory 12-month participation requirement with changes permitted only during Annual Open Enrollment following 12 months of continuous participation.

Elect Legal Resources ☐ **Waive Coverage ☐**

CONFIRMATION OF ENROLLMENT

Sign and date the confirmation of your enrollment below.

I understand that:

- The information provided above is true and correct to the best of my knowledge.

- The coverage will become effective according to GW's eligibility guidelines following approval of this application.
- Should any material answers or statements contained in this application be untrue, then the coverage may be cancelled and I will be subject to disciplinary action up to and including termination. Further, I may be required to repay payments made in error to me or on my behalf or on behalf of any covered family member as the result of the erroneous information.
- I authorize any provider to forward to the carrier information concerning medical services or supplies provided to me or to any of my family members listed on this application for the purpose of review, investigation or payment of a claim. This authorization is valid for the duration of the coverage.
- A copy of this application is available to the subscriber (or a person authorized to act on his/her behalf) upon request.
- Any person who with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive information may be guilty of insurance fraud.

I hereby apply for the group benefit(s) indicated above. I authorize my employer to take deductions from my pay on a pre-tax or post-tax basis as described in the enrollment materials. I understand that my elections cannot be changed or terminated during the plan year and will remain in effect, unless there is a change in my family status called a Qualified Life Event (e.g., marriage, divorce, birth or adoption of child, etc.). Any changes made as a result of a Qualified Life Event must be consistent with the event.

Signature: _____ Date: _____

COMPLETE YOUR ENROLLMENT

You can submit your completed, signed and dated enrollment form to Benefits via email, fax or postal mail.

By email, scan and email to: benefits@gwu.edu

Please Note: if using your GW email, enter the word **ENCRYPT** in the subject line to send the enrollment form and/or supporting documents securely. If using another email, please password-protect your submission or send by fax or postal mail.

By fax, send to (571) 553-8385

By postal mail, send to the following address:
GW Benefits
45155 Research Place, Suite 160
Ashburn, VA 20147