



**2009
Benefits
Election Form**

UST Benefits Election Form

January 2009 - December 2009

Name		Home Telephone	
Home Address	City	State	Zip
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
UST ID #	Office Phone	Mail #	<input type="checkbox"/> Hourly <input type="checkbox"/> Salaried

This Election Form is used in conjunction with the benefit materials enclosed. Refer to those materials before you complete this form. If hired on or after January 1, 2009, please return this form to the HR Dept. within 30 days of your hire date.

MEDICAL COVERAGE CHOICES

Administered by Blue Cross and Blue Shield of Minnesota (www.bluecrossmn.com) Group EP347	UST Monthly Subsidy	Your Monthly Cost	Your Cost Per Pay Period
<input type="checkbox"/> KEEP MY CURRENT COVERAGE			
Platinum Plan: <input type="checkbox"/> Employee Only	\$ 335.92	\$ 237.84	\$ 118.92
<input type="checkbox"/> Employee + 1	\$ 532.73	\$ 519.94	\$ 259.97
<input type="checkbox"/> Employee + Family	\$ 715.71	\$ 698.56	\$ 349.28
Gold Plan: <input type="checkbox"/> Employee Only	\$ 335.92	\$ 148.84	\$ 74.42
<input type="checkbox"/> Employee + 1	\$ 532.73	\$ 356.62	\$ 178.31
<input type="checkbox"/> Employee + Family	\$ 715.71	\$ 479.14	\$ 239.57
Silver Plan: <input type="checkbox"/> Employee Only	\$ 335.92	\$ 118.68	\$ 59.34
<input type="checkbox"/> Employee + 1	\$ 532.73	\$ 301.30	\$ 150.65
<input type="checkbox"/> Employee + Family	\$ 715.71	\$ 404.84	\$ 202.42
Bronze Plan: <input type="checkbox"/> Employee Only	\$ 335.92	\$ 86.66	\$ 43.34
<input type="checkbox"/> Employee + 1	\$ 532.73	\$ 242.56	\$ 121.28
<input type="checkbox"/> Employee + Family	\$ 715.71	\$ 325.90	\$ 162.95
High Deductible Health Plan (HDHP):			
<input type="checkbox"/> Employee Only	\$ 335.92	\$ 73.22	\$ 36.61
<input type="checkbox"/> Employee + 1	\$ 532.73	\$ 217.90	\$ 108.95
<input type="checkbox"/> Employee + Family	\$ 715.71	\$ 292.78	\$ 146.39
<input type="checkbox"/> WAIVE COVERAGE (Complete Waiver Form)	\$ 0	\$ 0	\$ 0
Health Savings Account (HSA) ONLY available with the HDHP 2009 annual limit: \$3,000 Single/\$5,950 Family age 55 or over: \$4,000 Single/\$6,950 Family		Enter your 2009 HSA Amount: (Must complete HSA enrollment form) \$ _____	

*The University of St. Thomas policy permits you to waive medical coverage only if you name your health insurance provider as proof of other coverage. See the enclosed waiver forms in your Enrollment materials.

DENTAL COVERAGE CHOICES

Administered by Delta Dental (www.deltadentalmn.org) Group 4070	UST Monthly Subsidy	Your Monthly Cost	Your Cost Per Pay Period
<input type="checkbox"/> KEEP MY CURRENT COVERAGE			
<input type="checkbox"/> Employee Only	\$ 8.65	\$ 25.08	\$ 12.54
<input type="checkbox"/> Employee + Family	\$ 17.23	\$ 90.90	\$ 45.45
<input type="checkbox"/> WAIVE COVERAGE (Complete Waiver Form)	\$ 0	\$ 0	\$ 0

VISION COVERAGE CHOICES

Administered by EyeMed (www.eyemedvision.com) Group 9724550	Total Monthly Cost	Your Cost Per Pay Period
<input type="checkbox"/> KEEP MY CURRENT COVERAGE		
Plan A: <input type="checkbox"/> Employee Only	\$ 5.72	\$ 2.86
<input type="checkbox"/> Employee + Family	\$15.40	\$ 7.70
Plan B: <input type="checkbox"/> Employee Only	\$ 6.72	\$ 3.36
<input type="checkbox"/> Employee + Family	\$17.40	\$ 8.70
Plan C: <input type="checkbox"/> Employee Only	\$ 7.06	\$ 3.53
<input type="checkbox"/> Employee + Family	\$18.96	\$ 9.48
<input type="checkbox"/> WAIVE COVERAGE	\$ 0	\$ 0

ELIGIBILITY INFORMATION – NOTE: If you are not adding or changing your dependents, you are not required to complete this section.

Dependent(s) First and Last Name	Gender		Relation-ship to you	Date of Birth	Add or Drop your Dependent from Coverage		Full Time Student		Coverage Type To Add or Drop				
	M	F			Add	Drop	Yes	No	Med	Dent	Vision	All	

If you are making a change to the dependents to be covered, please check reasons for change and write the date of event.

- | | |
|---|--|
| <input type="checkbox"/> Marriage _____ (date) | <input type="checkbox"/> Dependent eligible due to student status _____ (date) |
| <input type="checkbox"/> Divorce _____ (date) | <input type="checkbox"/> Lost other coverage _____ (date) |
| <input type="checkbox"/> Birth of child _____ (date) | <input type="checkbox"/> Other (state reason) _____ (date) |
| <input type="checkbox"/> Adoption _____ (date) | <input type="checkbox"/> Termination Date _____ |
| <input type="checkbox"/> Dependent child ineligible due to age and/or student status _____ (date) | |

NOTE: Dependent children age 19 to 25 must be full-time students attending classes to be covered by medical, dental and/or vision plan.

All changes must be received within 30 days of the event (except for birth or adoption of a child you have 90 days). If not made within the required timeframe, the change cannot be honored until the next annual enrollment.

SPENDING ACCOUNT CHOICES *Based on Your Plan Year (Generally Jan. 1-Dec. 31)

Administered by Administration Resources Corporation (ARC)
(www.arcbenefitaccess.com)

Health Care Spending Account—minimum amount, if elected, is \$100, maximum is \$5,000.

Enter your 2009 health care spending amount.

\$ _____

AND / OR

Dependent Care Spending Account—minimum amount, if elected, is \$100, maximum is \$5,000.

Enter your 2009 dependent care spending amount.

\$ _____

*In making your elections, please refer to the portions of the benefit materials regarding eligible expenses and spending account rules. When no amounts are listed, that will indicate you have chosen not to participate in the spending account(s) for the 2009 plan year.

By signing below, I certify that I have received the printed materials explaining the University of St. Thomas Cafeteria Plan and my program choices. I understand that by signing and submitting this form, I am making a binding election for the choices indicated above. I understand I cannot change these elections except as described in the benefit materials and that any amounts remaining in my spending accounts shall be forfeited if not used. In addition, I hereby authorize the pre-tax deduction indicated above.

Signature	Today's Date
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