Benefit Election Form - Plan year 01/01/24 – 12/31/24
Rates shown are per Pay Period

Name	Hire Date	WSU ID Number	Social Security Number

Address	City	State	Zip Code	Date of Birth

BCBS Medical + Dental

You are currently enrolled in:

Please Select: ☐ No Changes ☐ Enroll ☐ Make a Change

Option 2 - $5000 + Dental	☐ $47.80	☐ $206.96	☐ $192.00	$452.33 ☐ $342.54	

B. If you are ADDING or REMOVING a Spouse and/or Dependent on your Medical, please complete below:

☐ ADD ☐ REMOVE	☐ Male ☐ Female	Spouse Name:	Date of Birth	Social Security Number:
☐ ADD	☐ Male	(1) Child Name:	Date of Birth	Social Security Number:

☐ REMOVE	☐ Female			
☐ ADD ☐ REMOVE	☐ Male ☐ Female	(4) Child Name:	Date of Birth	Social Security Number:

☐ I am covered by another group plan (spouse's plan, parent's plan or other employer plan)
☐ I am covered by an individual medical plan
☐ I am covered by Medicare
☐ Other: ____

Surency Vision