Summary of Benefits Worksheet

Please complete this document and bring it with you to your Benefits Selection Meeting. You may also email this document to the Benefits Representative prior to your meeting.

Health Insurance – *Refuse or select one plan*

Plan:
□ Refuse
□ *State Savings Health Plan
□ State Standard Health Plan

Coverage Level:
□ Employee Only
□ Employee/Spouse
□ Employee/Child(ren)
□ Full Family

State Dental Plan – *If electing Dental Plus, you must enroll in Basic Dental and cover the same individuals*

Basic Dental:
□ Refuse
□ Employee Only
□ Employee/Spouse
□ Employee/Child(ren)
□ Full Family

Dental Plus:
□ Refuse
□ Yes

EyeMed State Vision
□ Refuse
□ Employee Only
□ Employee/Spouse
□ Employee/Child(ren)
□ Full Family

Vision Discount Program - Free

Basic Life - $3,000.00 coverage for free by choosing a Health Plan

Optional Life – *Please refer to Optional Life Rate Sheet for current rates – new hires can elect up to 3x's annual salary without providing medical evidence*
□ Refuse
□ Coverage Level $_____

Dependent Life/Spouse *– New hires may elect either $10,000 or $20,000 on a spouse, rates are based on the age of the employee – Please refer to Optional Life Rate Sheet*

□ Refuse
□ Coverage Level $_____

**Participants in the State Savings Health Plan may enroll in a Health Savings Account. Please see a Benefits Representative for more information.*

Dependent Life/Child - *$1.10/month regardless of number of children covered – if over the age of 19, student certification is required*
□ Refuse
□ Enroll - $15,000

Basic Long Term Disability – free by choosing a Health Plan

Supplemental Long Term Disability – *Refuse or select one plan – formula to calculate rate is reflected on Active Monthly Insurance Rates*
□ Refuse
□ Plan One – 90-day benefit waiting period
□ Plan Two – 180-day benefit waiting period

Pre-taxed Monthly Health, Dental, and Vision Premiums (1st $50,000 of Optional Life Insurance will be pre-tax)
□ Refuse
□ Yes

Retirement Plan – *required for full-time permanent positions*
□ South Carolina Retirement Systems (SCRS)
□ Police Officer Retirement Systems (PORS)
- **only** full-time police officers may enroll in PORS
□ ORP – Optional Retirement Plan – must select a vendor from the list below

□ TIAA □ VALIC
□ MassMutual □ MetLife

I certify that I have attended the *New Hire Benefits Orientation* containing information related to benefits at Winthrop University.

I have been advised of the availability of state benefits and was given the opportunity to enroll in all programs.

I understand that I am responsible for my benefits and it is my responsibility to inform the Benefits Administrator of Winthrop University within the appropriate time frame if/when changes need to be made to my coverage.

EMPLOYEE SIGNATURE **DATE**

Beneficiary Information will be required if enrolling in a health plan, optional life, and retirement plan. Please be prepared to submit the following:

Beneficiaries:

Beneficiary Name: ________________________
Relationship: ________________________
Date of Birth: ____/____/________
Social Security Number: ______-____-________
□ Basic Life – □ Primary □ Contingent
□ Optional Life – □ Primary □ Contingent
□ Retirement Funds – □ Primary □ Contingent
□ Incidental Death Benefit – Primary Only

Beneficiary Name: ________________________
Relationship: ________________________
Date of Birth: ____/____/________
Social Security Number: ______-____-________
□ Basic Life – □ Primary □ Contingent
□ Optional Life – □ Primary □ Contingent
□ Retirement Funds – □ Primary □ Contingent
□ Incidental Death Benefit – Primary Only

Beneficiary Name: ________________________
Relationship: ________________________
Date of Birth: ____/____/________
Social Security Number: ______-____-________
□ Basic Life – □ Primary □ Contingent
□ Optional Life – □ Primary □ Contingent
□ Retirement Funds – □ Primary □ Contingent
□ Incidental Death Benefit – Primary Only

Most common forms of required Dependent Eligibility Documentation:

Legal Spouse:

- Marriage License

  – OR –

- Page 1 of Federal Tax Return

Natural Children:

- Copy of long form birth certificate showing the subscriber as the parent

Step Child(ren):

- A copy of the long form birth certificate showing the name of the natural parent

  – PLUS –

- Proof that the natural parent and the subscriber are married

Adopted Child(ren):

- A copy of the long form birth certificate showing the subscriber as the parent
- Court document verifying completed adoption
- Letter of placement verifying the adoption is in process

Foster Child(ren):

- Court order or other legal document placing the child with the subscriber, who is a licensed foster parent

Please refer to the attached Enrollment Eligibility Documentation Worksheet for a complete list of acceptable documents.

If married, the following information must be completed: *(Even if not enrolling in benefits)*

Spouse's Name: ________________________
(□ Male □ Female) (□ Husband □ Wife)
Date of Birth: ____/____/________
Social Security Number: ______-____-________
Enroll in: □ Health □ Dental □ Vision □ Life

Dependents:

Dependent Name: ________________________
Relationship: ________________________
(□ Male □ Female) (□ Husband □ Wife)
Date of Birth: ____/____/________
Social Security Number: ______-____-________
Enroll in: □ Health □ Dental □ Vision □ Life

Dependent Name: ________________________
Relationship: ________________________
(□ Male □ Female) (□ Husband □ Wife)
Date of Birth: ____/____/________
Social Security Number: ______-____-________
Enroll in: □ Health □ Dental □ Vision □ Life

Dependent Name: ________________________
Relationship: ________________________
(□ Male □ Female) (□ Husband □ Wife)
Date of Birth: ____/____/________
Social Security Number: ______-____-________
Enroll in: □ Health □ Dental □ Vision □ Life

Dependent Name: ________________________
Relationship: ________________________
(□ Male □ Female) (□ Husband □ Wife)
Date of Birth: ____/____/________
Social Security Number: ______-____-________
Enroll in: □ Health □ Dental □ Vision □ Life

Dependent Name: ________________________
Relationship: ________________________
(□ Male □ Female) (□ Husband □ Wife)
Date of Birth: ____/____/________
Social Security Number: ______-____-________
Enroll in: □ Health □ Dental □ Vision □ Life

Dependent Name: ________________________
Relationship: ________________________
(□ Male □ Female) (□ Husband □ Wife)
Date of Birth: ____/____/________
Social Security Number: ______-____-________
Enroll in: □ Health □ Dental □ Vision □ Life