

LINDSEY WILSON COLLEGE ANTHEM HEALTH INSURANCE ELECTION FORM FOR PLAN YEAR 2024

I hereby elect the following health insurance plan for the 2024 plan year:

<input type="checkbox"/>	Single Core Plan MO	\$180.00
<input type="checkbox"/>	Single Buy Up Plan MO	\$240.00
<input type="checkbox"/>	Employee & Spouse Core Plan MO	\$995.00
<input type="checkbox"/>	Employee & Spouse Buy Up Plan MO	\$1,147.00
<input type="checkbox"/>	Employee & Children Core Plan MO	\$885.00
<input type="checkbox"/>	Employee & Children Buy Up Plan MO	\$1,037.00
<input type="checkbox"/>	Family Core Plan MO	\$1,007.00
<input type="checkbox"/>	Family Buy Up Plan MO	\$1,159.00
<input type="checkbox"/>	Dual Employee Family Core Plan MO	\$593.77
<input type="checkbox"/>	Dual Employee Family Buy Up Plan MO	\$745.77

<input type="checkbox"/>	Single Core Plan BW	\$90.00
<input type="checkbox"/>	Single Buy Up Plan BW	\$120.00
<input type="checkbox"/>	Employee & Spouse Core Plan BW	\$497.50
<input type="checkbox"/>	Employee & Spouse Buy Up Plan BW	\$573.50
<input type="checkbox"/>	Employee & Children Core Plan BW	\$442.50
<input type="checkbox"/>	Employee & Children Buy Up Plan BW	\$518.50
<input type="checkbox"/>	Family Core Plan BW	\$503.50
<input type="checkbox"/>	Family Buy Up Plan BW	\$579.50
<input type="checkbox"/>	Dual Employee Family Core Plan BW	\$296.89
<input type="checkbox"/>	Dual Employee Family Buy Up Plan BW	\$372.89

I waive participation in the 2024 health insurance plan year.

Print Name

Employee ID#

Signature

Date

Termination Notification Form
LINDSEY WILSON COLLEGE

Please submit forms to:

Aspirant
500 N. Hurstbourne Pkwy Ste. 100
Louisville, KY 40222

Toll Free: 855-982-2583
Email: eligibility@aspirant.us

Employee Name	SS# or Member ID	Date of Birth
Address	City	State Zip

Date of Termination: _____

Reason:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> End of Employment | <input type="checkbox"/> Voluntary | <input type="checkbox"/> Involuntary |
| <input type="checkbox"/> Reduction in Hours of Employment | <input type="checkbox"/> Voluntary | <input type="checkbox"/> Involuntary |
| <input type="checkbox"/> Death of Employee | <input type="checkbox"/> Divorce or Legal Separation | |
| <input type="checkbox"/> Entitlement to Medicare | <input type="checkbox"/> Loss of Dependent Status | |
| <input type="checkbox"/> Leave of Absence | | |

Type of Coverage:

- | | | | | |
|----------|--|--|--|---------------------------------|
| MEDICAL: | <input type="checkbox"/> CORE | <input type="checkbox"/> BUY UP | | |
| | <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE & SPOUSE | <input type="checkbox"/> EMPLOYEE & CHILD(REN) | <input type="checkbox"/> FAMILY |
| DENTAL: | <input type="checkbox"/> CORE | <input type="checkbox"/> BUY UP | | |
| | <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE & SPOUSE | <input type="checkbox"/> EMPLOYEE & CHILD(REN) | <input type="checkbox"/> FAMILY |
| VISION: | <input type="checkbox"/> LOW OPTION | <input type="checkbox"/> HIGH OPTION | | |
| | <input type="checkbox"/> EMPLOYEE ONLY | <input type="checkbox"/> EMPLOYEE & SPOUSE | <input type="checkbox"/> EMPLOYEE & CHILD(REN) | <input type="checkbox"/> FAMILY |

	<u>Date of Birth</u>	<u>SSN</u>
Spouse: _____	_____	_____
Child 1: _____	_____	_____
Child 2: _____	_____	_____
Child 3: _____	_____	_____
Child 4: _____	_____	_____

Please note that terminations cannot be made in Aspirant’s system or in the Pharmacy Benefit Manager’s system until Aspirant has been notified of a termination. Pharmacy claims incurred on late terminations cannot be recouped.

Employer Representative Signature

Date