LINDSEY WILSON COLLEGE
ANTHEM HEALTH INSURANCE ELECTION FORM
FOR PLAN YEAR 2025

I hereby elect the following health insurance plan for the 2025 plan year:

☐	Single Core Plan MO	$180.00
☐	Single Buy Up Plan MO	$254.00
☐	Employee & Spouse Core Plan MO	$726.00
☐	Employee & Spouse Buy Up Plan MO	$888.00
☐	Employee & Children Core Plan MO	$531.00
☐	Employee & Children Buy Up Plan MO	$664.00
☐	Family Core Plan MO	$966.00
☐	Family Buy Up Plan MO	$1,181.00
☐	Dual Employee Family Core Plan MO	$502.00
☐	Dual Employee Family Buy Up Plan MO	$717.00

☐	Single Core Plan BW	$90.00
☐	Single Buy Up Plan BW	$127.00
☐	Employee & Spouse Core Plan BW	$363.00
☐	Employee & Spouse Buy Up Plan BW	$444.00
☐	Employee & Children Core Plan BW	$265.50
☐	Employee & Children Buy Up Plan BW	$332.00
☐	Family Core Plan BW	$483.00
☐	Family Buy Up Plan BW	$590.50
☐	Dual Employee Family Core Plan BW	$251.00
☐	Dual Employee Family Buy Up Plan BW	$358.50

☐ I waive participation in the 2025 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:

☐ End of Employment ☐ Voluntary ☐ Involuntary
☐ Reduction in Hours of Employment ☐ Voluntary ☐ Involuntary

☐ Death of Employee ☐ Divorce or Legal Separation
☐ Entitlement to Medicare ☐ Loss of Dependent Status
☐ Leave of Absence

Type of Coverage:

MEDICAL: ☐ CORE ☐ BUY UP
☐ EMPLOYEE ONLY ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ FAMILY

DENTAL: ☐ CORE ☐ BUY UP
☐ EMPLOYEE ONLY ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ FAMILY

VISION: ☐ LOW OPTION ☐ HIGH OPTION
☐ EMPLOYEE ONLY ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & CHILD(REN) ☐ FAMILY

	Dependent Name	Date of Birth	SSN
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**

_____ _____
Employee Signature **Date**