Cleveland State University

PART-TIME BENEFITS ENROLLMENT

☐ New Hire ☐Change (Describe) ________________________ Effective Date ______________

Employee______________________________ SS#______________ CSU ID#__________
(Please Print) Last First MI

Address____ ______________
Number Street City State Zip Code Campus Extension

Employee and Dependent Information (Must List ALL Dependents Affected By Enrollment/Change)

Add Delete	Last Name	First Name	Relationship	M/F	SS#	Date of Birth
	Employee		Self			
	Dependent					
	Dependent					
	Dependent					
	Dependent					

Medical Kaiser Permanente HMO

Single	Family
$318.00	$848.00

(Group No. 0503-002)

If insured by another plan, please provide:

Plan Name/Employer______________________

Insurance Co. /Group #______________________

Flexible Spending Accounts (Vantage Financial)

☐ Health Care Total: $ __________ per fiscal year*

☐ Dependent Care Total: $ __________ per fiscal year*

*Fiscal year amount will be converted to a per pay deduction amount based on your current contract and the number of pays remaining in the fiscal year. Rounding may apply.

HR Use Only	HRIS	Vendor
Coverage Eff. Date:	______	______
Deduction Begin Date:	______	
Coverage End Date:	______	
Deduction End Date:	______	
1st FSA Pay Date:		______
Last FSA Pay Date:		______

SM 24 SM 18 BW 24

$________(HC) $________(DC) X ______ Pays Remaining

Optional Life Insurance (The Standard Insurance Company Policy No. 136437-B)

Enroll *(Complete the Standard Insurance Company application when electing amounts over $50,000 – Call X3636 for a form)*

Amount $ ______________ (Minimum $ 10,000; Maximum $ 150,000)

Beneficiary	Relationship	M/F	Social Security # / Date of Birth	Percent
Primary				
Secondary				

Agreement/Signature

I agree to pre-tax payroll contributions, if applicable, and understand that my participation and benefits are subject to applicable plan documents and IRS rules and may not be changed at any time during the plan year unless I experience a qualifying event as defined by the IRS. Falsification of information may result in disciplinary action, up to and including termination. Information on this form may be used and disclosed to facilitate enrollment in the benefit plans you have elected. I certify that the information provided here is correct and the listed dependents qualify for benefits according to the benefit plan documents and the IRS rules.

______________________________ ______________

Signature Date

M ______ ______________ ___________
D ______ ______________ ___________
V ______ ______________ ___________
F ______ ______________ ___________
PS ______ ______________ ___________

Return to: CSU Benefits Services • 2121 Euclid Avenue AC 113 • 216.687.3636 • 216.687.3976 (fax)

Revised 3/23/2007