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| **McPherson College**  **2025 Benefit Election Form**  Please Print Legibly  **Name: Address:**  **City: State Zip**  **Email: Gender:** □ Male □ Female  **Date of Birth:** / / **Social Security Number: ─ ─**  **Annual Salary: Date of Hire:** / /  **Job Title: Location:**  **Phone (Work): Phone (Home or Cell):** | | | | | | | | | | | | |
| **Coverage** | **EE Only** | **EE + SP** |  | | | | **EE + CH** | | **FAM** | **Waive** |  | |
| **Group Paid Basic Life with AD&D** |  | Sunlife $10k | | | | | | | | |
| **Group Paid Long Term Disability** |  | SunLife effective the 1st of the month or 1st of the month following 30 days of employment. | | | | | | | | |
| **HSA: WEX Discovery** | **Yearly** Personal HSA Deduction: $\_ | | | | | | | |  | □ |
| **Vision: Sunlife Vision** | $8.99  □ | $18.90  □ |  | | | | $16.23  □ | | $30.32  □ | □ |
| **Flexible Spending Account (FSA Medical or Dependent Care )**  WEX Discovery | □ | **Yearly Medical Deduction**: $\_\_\_\_\_\_\_ **Yearly Dependent Care Deduction** $\_\_\_\_\_\_\_\_\_\_ | | | | | | | | □ |
| **Voluntary Sunlife** Guarantee Issue: Employee $100k Spouse $25k Child(ren) $10k | Employee Coverage  $ | | Spouse Coverage  $ | | | | Child Coverage $ | | | □ |
| Life Insurance Enrollment is only allowed up to the listed guarantee issue amounts within 30 Days of Date of Hire.  Any amount over the Guarantee Issue will require Evidence of Insurability and must be approved by the Insurance Company. | | | | | | | | | | |
| **Short-Term Disability**  Sunlife | Elimination Period  □ 8 Days □ 15 Days □ 31 Days | | | | Weekly Volume  $25 up to 60% Earnings  $ / week | | | | | □ |
| **Accident: Sunlife** | $9.29  □ | $15.72  □ |  | | | | $19.37  □ | | $25.80  □ | □ |
| **Hospital Indemnity: Sunlife** | $17.94 | $36.16 | |  | | $28.70 | | $46.92 | | □ |
| **Critical Illness Including Cancer/ICU**  **See back of form for rates.** | Employee  □ | *Health Questions must be answered.*  Children  Spouse  □ □ | | | | | | | | □ |
| **ID Theft: Allstate** | $7.95  □ |  | | | | | | | $13.95  □ | □ |
| Complete enrollment form within 30 Days of your Date of Hire if a newly hired employee.  Benefits and payroll deductions will begin the first of the month following 30 Days of Employment.  Please refer to Policy Flyers and Contracts for Plan Specifics and Claim Payment Details.  Please reach out to Brenda Stocklin-Smith if you have questions about these benefits.  Office: (620) 242-0454, Email: [stocklib@mcpherson.edu](mailto:stocklib@mcpherson.edu)  Please return your completed form to Brenda Stocklin-Smith of the McPherson College HR Dept within 30 Days of employment or if change occurs due to a qualifying event.  **Employee's Signature: Date: /\_ /\_**  **Meet with HR \_\_\_\_\_**  **Enrolled Maxwell \_\_\_\_\_**  **Entered into PR\_\_\_\_\_\_** | | | | | | | | | | | | |

10/03/2024





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| --- | --- | --- | --- | --- |
| **McPherson College**  **2025 Benefit Election Form**  Please Print Legibly  *Dependents (if applicable)* | | | | |
| **Spouse** □ M □ F Name: **Date of Birth:**  **Child(ren)** □ M □ F Name: **Date of Birth:**  □ M □ F Name: **Date of Birth:**  □ M □ F Name: **Date of Birth:**  □ M □ F Name: **Date of Birth:** | | | / / | |
| / / | |
| / / | |
| / / | |
| / / | |
| *If more dependents are needed, please append additional page*  *Required : Please indicate one or more Beneficiaries:* | | | | |
| **Primary Beneficiaries** |  | | | |
| **Full Name: Relation: DOB: Percent:** | | | | |
| **Address:** | | **Relation: DOB: Percent:** | |  |
| **Full Name:** | |  |
| **Address:** | |  |
| **Contingent Beneficiaries** |  | | | |
| **Full Name: Relation: DOB: Percent:** | | | | |
| **Address:** | | | | |
| **Full Name: Relation: DOB: Percent:** | | | | |
| **Address:** | | | | |
| **Employee's Signature: Date: /\_ /\_** | | | | |

Rates are effective as of January 01, 2025. The chart below shows possible coverage amounts and the corresponding costs per monthly pay period. Find your age bracket (as of the effective date of coverage) to determine the associated cost for the coverage amount you choose.

Employee Critical Illness - Choice 1 Non-tobacco rates Age and cost - pay period (monthly) premium

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Coverage amounts | <30 | 30-39 | 40-49 | 50-59 | 60-69 | 70+ |
| $10,000 | 5.00 | 8.30 | 18.40 | 36.70 | 62.50 | 114.60 |
| $20,000 | 10.00 | 16.60 | 36.80 | 73.40 | 125.00 | 229.20 |
| $30,000 | 15.00 | 24.90 | 55.20 | 110.10 | 187.50 | 343.80 |
| $40,000 | 20.00 | 33.20 | 73.60 | 146.80 | 250.00 | 458.40 |

Employee Critical Illness - Choice 1 Tobacco rates Age and cost - pay period (monthly) premium

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Coverage amounts | <30 | 30-39 | 40-49 | 50-59 | 60-69 | 70+ |
| $10,000 | 5.30 | 10.40 | 28.50 | 67.40 | 125.50 | 218.80 |
| $20,000 | 10.60 | 20.80 | 57.00 | 134.80 | 251.00 | 437.60 |
| $30,000 | 15.90 | 31.20 | 85.50 | 202.20 | 376.50 | 656.40 |
| $40,000 | 21.20 | 41.60 | 114.00 | 269.60 | 502.00 | 875.20 |

Rates are effective as of January 01, 2025. The chart below shows possible coverage amounts and the corresponding costs per monthly pay period. Find your age bracket (as of the effective date of coverage) to determine the associated cost for the coverage amount you choose.

Spouse Critical Illness - Choice 1 Non-tobacco rates Age and cost - pay period (monthly) premium

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Coverage amounts | <30 | 30-39 | 40-49 | 50-59 | 60-69 | 70+ |
| $10,000 | 5.00 | 8.30 | 18.40 | 36.70 | 62.50 | 114.60 |
| $20,000 | 10.00 | 16.60 | 36.80 | 73.40 | 125.00 | 229.20 |
| $30,000 | 15.00 | 24.90 | 55.20 | 110.10 | 187.50 | 343.80 |
| $40,000 | 20.00 | 33.20 | 73.60 | 146.80 | 250.00 | 458.40 |

Spouse Critical Illness - Choice 1 Tobacco rates Age and cost - pay period (monthly) premium

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Coverage amounts | <30 | 30-39 | 40-49 | 50-59 | 60-69 | 70+ |  |  |  |  |  |  |  |
| $10,000 | 5.30 | 10.40 | 28.50 | 67.40 | 125.50 | 218.80 |  |  |  |  |  |  |  |
| $20,000 | 10.60 | 20.80 | 57.00 | 134.80 | 251.00 | 437.60 |  |  |  |  |  |  |  |
| $30,000 | 15.90 | 31.20 | 85.50 | 202.20 | 376.50 | 656.40 |  |  |  |  |  |  |  |
| $40,000 | 21.20 | 41.60 | 114.00 | 269.60 | 502.00 | 875.20 |  |  |  |  |  |  |  |

Rates are effective as of January 01, 2025. The chart below shows possible coverage amounts and the corresponding costs per monthly pay period.

Child(ren) Critical Illness - Choice 1

|  |  |
| --- | --- |
| Coverage amounts | Cost - pay period (monthly) premium |
| $5,000 | 3.65 |
| $10,000 | 7.30 |
| $15,000 | 10.95 |
| $20,000 | 14.60 |