

Benefit Election Form - Plan year 01/01/24 - 12/31/24
Rates shown are per Pay Period



Name	Hire Date	WSU ID Number	Social Security Number	
Address	City	State	Zip Code	Date of Birth

BCBS Medical + Dental

You are currently enrolled in:

Please Select: No Changes Enroll Make a Change

Option 2- \$5000+ Dental	<input type="checkbox"/> \$47.80	<input type="checkbox"/> \$206.96	<input type="checkbox"/> \$192.00	<input type="checkbox"/> \$342.54	<input type="checkbox"/> \$452.33
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B. If you are ADDING or REMOVING a Spouse and/or Dependent on your Medical, please complete below

<input type="checkbox"/> ADD	<input type="checkbox"/> Male	Spouse Name:	Date of Birth:	Social Security Number:
<input type="checkbox"/> REMOVE	<input type="checkbox"/> Female			

<input type="checkbox"/> ADD	<input type="checkbox"/> Male	(1) Child Name:	Date of Birth:	Social Security Number:
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<input type="checkbox"/> REMOVE	<input type="checkbox"/> Female			
<input type="checkbox"/> ADD	<input type="checkbox"/> Male	(4) Child Name:	Date of Birth:	Social Security Number:
<input type="checkbox"/> REMOVE	<input type="checkbox"/> Female			

I am covered by another group plan (spouse's plan, parent's plan or other employer plan)
 I am covered by an individual medical plan
 I am covered by Medicare
 Other: _____

