WICHITA STATE UNIVERSITY
INTERCOLLEGIATE ATHLETIC ASSOCIATION, INC.

Benefit Election Form - Plan year 01/01/25 – 12/31/25

Rates shown are per Pay Period

PLEASE COMPLETE ALL OF THE FIELDS:

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**

A. If you are ENROLLING or MAKING A CHANGE, please select:

	Employee Only	Employee + Spouse	Employee + Children	Family	Premium Amount
Option 1 - $1500 + Dental	☐ $82.37	☐ $281.28	☐ $262.04	☐ $452.33	
Option 2 - $5000 + Dental	☐ $47.80	☐ $206.96	☐ $192.00	☐ $342.54	

Surency Vision				
You are currently enrolled in:				
Please Select:	☐ **No Changes**	☐ **Enroll**	☐ **Make a Change**	☐ **Terminate**

If Enrolling or Changing, please select: **Employee Only** **Employee + Spou/ƨW*np**