

BENEFITS EN	ROLLI	MENT	FORM J	AN 1 – DE	C 31, 2024	4 I	hum	an.reso	urces@	vande	rbilt.edu		
Name:													
VUNetID:					Last four	of SS	SN:						
Event Type:					Event Dat	te:							
Please complete	e all se	ctions o	of this form. I	Failure to r	nake a sele	ction	า will	result in	waiving	coverag	ge for 2024.		
Health: Check the b													
<u>Health Plan</u>			age Category										
□ Aetna Choice C		□ Emp	-		□ Emplo	-	- Chil	d(ren)					
□ Aetna Select PF	-	□ Employee + Spouse □ Family											
□ Aetna International (J1-T Only)		 □ I attest that my spouse does not have coverage available anywhere else. □ I am or my dependent is a tobacco user. 											
□ Waive Coverage	۵	□Iam	or my deper	ident is a to	opacco user	•							
Dental: Check the b		vour de	ntal nlan ch	oice and c	overage cat	tegor	rv						
Dental Plan	, ox 101		age Category	orec arra c	overage car	eego.							
□ Delta Dental Ba	sic	□ Emp			□ Emplo	yee +	- Chile	d(ren)					
□ Delta Dental Pr	emier	□ Emp	oloyee + Spou	se	□ Family	,							
□ Waive Coverage	е												
Vision: Check the b	ox for y		•	ice and co	verage cate	gory	/						
<u>Vision Plan</u>			age Category				Ch:I	-l ()					
□ Delta Vision □ Waive Coverage	2	□ Emp	oloyee oloyee + Spou	50	□ Emplo □ Family	-	- Chile	a(ren)					
		LIII	noyee - Spou	3C	□ I allilly	<u>'</u>							
Dependents:	I = 1		0011			T			l				
<u>Name</u>	Relation	<u>onship</u>	<u>SSN</u>	<u>DOB</u>	<u>Gender</u>		<u>alth</u>	<u>Dental</u>	<u>Vision</u>	AD&D	Beneficiary %		
							Ш						
						1 [
Health Care FSA	II.				l					I.	l		
(only if enrolled in Selec	ct or	□ Yes □ No											
waived medical)							Ann	ual Deduc	tion Amo	unt: \$			
Dependent Care FS	ρA	□ Yes	□ No derstand the t	was of ove	oncoc that								
			ify under the		renses that		Δnn	ual Deduc	tion Amo	unt·\$			
Health Savings Acc	ount	□ Yes	□ No				7.1111	uai Deau		ranc. y			
(only if enrolled in CDHI			ree to the Terr	ns & Condit	tions found o	on							
		_	'U Benefits we				Ann	ual Deduc	tion Amo	unt· \$			
Basic Life Insuranc	e	□ 1x P	ay 🗆 \$50,0	000			7	uat Deau		· · · · · · ·			
Complemental Life		- Cala	at Cavarage	= \\\ai\\\ai\\\ai\\\\ai\\\\ai\\\\ai\\\\ai\\\\\ai\\\\\\	Cayara 53								
Supplemental Life			ct Coverage ay select cove		Coverage								
Insurance (Evidence of Insurability	, is		l salary	ruge at ix t	to ox your								
required over \$500,000)			,				Ann	ual Cover	aga Amai	ıntı			
Spouse Life Insura	nce	□ Sele	ct Coverage	□ Waive	Coverage		AIIII	ual Cover	age Amot	ли. -			
(Evidence of Insurability			ay select cove		_								
required)	•		0 up to \$250,0	-	-		Ann	ual Cover	age Amoı	ınt: \$			
Child Life Insuranc	e	□ \$5,0	00	□ Waive	Coverage								
		□ \$10,											
Voluntom, Assistant	hal	□ \$15,		idual –	Family								
Voluntary Accident Death and	lal		ve □ Indiv ay select cove		Family rements of								
Dismemberment			0 up to \$500,0	-	2		Flac	tion Amo	unt· \$				



Short Term Disability	□ Select Buy-up □ Waive Coverage						
Buy-Up	 Vanderbilt pays for the full cost of base STD coverage. 						
	 This base coverage replaces 66.67% of your weekly wage 	es up to a maximum of \$308 per					
	week while you are disabled. You must select the Buy-Up	o coverage to replace a larger					
	portion of your income, up to \$5,000 per week.						
Long Term Disability	□ Select Buy-up □ Waive Coverage						
Buy-up	 Vanderbilt pays for the full cost of base LTD coverage. 						
	 Base coverage replaces 60% of your monthly wages up to 	o a maximum monthly benefit					
	of \$1,200 while you remain disabled. You must select the	e Buy-Up coverage o to replace a					
	larger portion of your income, up to \$33,000 per month.						
<u> </u>	concerning the above-described benefits. I authorize applicable pa	•					
 I am making an election choices indicated. This is I cannot revoke or chan consistent with the IRS election. I verify and affirm that t 	concerning the above-described benefits. I authorize applicable parelection is subject to any changes required to comply with federal or ge this election during the plan year unless there is a qualifying life or rules relating to a change in family status. If such a change occurs, I he dependents enrolled for Health, Dental and/or Vision coverage anderstand misrepresenting dependent eligibility is subject to disciple	or state tax laws. event. This change must be may then revoke my earlier are eligible under the terms of					
 I am making an election choices indicated. This of a cannot revoke or chan consistent with the IRS election. I verify and affirm that the applicable plan. I under the applicable plan. 	election is subject to any changes required to comply with federal oge this election during the plan year unless there is a qualifying life erules relating to a change in family status. If such a change occurs, I he dependents enrolled for Health, Dental and/or Vision coverage a	or state tax laws. event. This change must be may then revoke my earlier are eligible under the terms of					

Date: __

Initials: __

For office use only.

Checked for completeness: _