Vincennes University

2024 Voluntary Enrollment Form

Name: _____ DOB: _____ Sex: _____

SS#: _____ Dependent Children: YES _____ NO _____

Spouse: _____ DOB: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone ( ) _____

Please select the optional coverage you want. Circle the applicable prices and write the amount in the box in the far right column. All costs and credits provided are on a biweekly basis.

(26 Week Pay Schedule)

	Employee Only	Employee Plus One	Employee/Family	
☐ Paramount Dental	**$10.47**	**$22.08** *spouse **OR** 1 child	**$38.24**	

		Individual	One Parent Family	EE & Spouse	Two Parent Family	
☐ AFLAC	Option 1	**$7.66**	**$7.66**	**$12.16**	**$12.16**	
	Option 2	**$15.46**	**$15.46**	**$26.60**	**$26.60**	
	Option 3	**$21.86**	**$21.86**	**$37.32**	**$37.32**	

	Single	Employee/ Plus One*	Employee/ Children	Family	
☐ Vision Service Plan	**$6.48**	**$10.09** *spouse **OR** 1 child	**$10.29**	**$16.60**	

Payroll Deduction Authorization:
I hereby authorize my employer to deduct from my earnings the appropriate amounts for voluntary benefits. In addition, I understand any pre-tax elections cannot be changed or revoked prior to the next anniversary date, unless due to a change in status and permitted by my employer.

_____ _____
Signature Date

WAIVER
I certify that the features and benefits of the supplemental coverages being offered have been explained to me completely. I understand that these programs are offered through my employer by payroll deduction. I have decided to waive my opportunity to participate at this time and understand I cannot revoke this decision unless authorized by my employer.

_____ _____
Signature Date