

HEALTH INSURANCE MEANS TEST FORM

Plan Year: January 1, 2005 through JUNE 30, 2005

Employee Name: _____ ID#: _____ SSN: _____

IMPORTANT: This form must be completed in order to continue the AU health insurance plan.
Coverage will be **terminated** if the completed form is not returned by December 22.

1. Marital Status:

- Single - go to Question 5.
- Married - go to Question 2.
- Divorced - go to Question 3.

2. My spouse:

- is a full-time student - go to Question 3.
- is an employee of Andrews University
 - I am the primary policy holder for my family - go to Question 3.
 - my spouse is the primary policy holder and I am listed on his/her health insurance - disregard the remaining questions, and sign this form.
- is neither employed nor self-employed. (If he/she will obtain employment AU Human Resources needs to be notified about this change.)
- does not work for Andrews University and is earning less than **\$28,044.00 gross** earnings/year (\$2337/month). **Attach 2003 W-2s and/or Schedule C.** Any pre-tax income not shown on the W-2, such as tax-sheltered annuities, etc., must be declared and added to the W-2 amounts. If spouse's income has changed since the 2003 W-2, please submit at least three (3) consecutive pay stubs that reflect earning under the means test.
The projected spouse earning for 2005 is \$ _____

Unless your spouse works primarily for AU or earns less than the above figures, he/she is not eligible for health care coverage; however, you can buy into the plan. If you have dependent children, you must also choose to either buy in for them or opt them out of the plan. **You cannot opt out yourself or your spouse, you can only receive opt out money for dependents who are children.**

- My spouse does not work for Andrews University, and earns more than \$28,044 gross earnings/year and
 - does wish to have the AU health insurance
 - does not wish to have the AU health insurance

Turn over →

3. List all family members on your insurance policy (do not include yourself):

Full Name	Birthdate	Relationship (spouse, child)

4. To be completed only by employees who want to buy in or opt out:

Full Name	Birthdate	Relationship	Selection
			<input type="checkbox"/> Opt Out <input type="checkbox"/> Buy In
			<input type="checkbox"/> Opt Out <input type="checkbox"/> Buy In
			<input type="checkbox"/> Opt Out <input type="checkbox"/> Buy In

5. Expected Monthly Deductions (check one):

<input type="checkbox"/>	Single (employee only)	\$50.00
<input type="checkbox"/>	Double (employee & 1 dependent)	\$75.00
<input type="checkbox"/>	Family (employee & 2 or more dependents)	\$100.00
<input type="checkbox"/>	Buy-in (employee only for class HH)	\$207.00
<input type="checkbox"/>	Buy-in 1 child	\$232.00
<input type="checkbox"/>	Buy-in 2+ children	\$305.00
<input type="checkbox"/>	Buy-in spouse only	\$389.00
<input type="checkbox"/>	Buy-in family (spouse and child or children)	\$461.00
<input type="checkbox"/>	Opt-Out 1 child	\$157.00*
<input type="checkbox"/>	Opt-Out 2+ children	\$205.00*

*taxable income

I certify that all of the above information is true and accurate to the best of my knowledge.

_____ (Employee Signature)

_____ (Date Signed)

Office Use Only	<input type="checkbox"/> Changed deduction in Banner Date _____	<input type="checkbox"/> Send change to IBA Date _____	<input type="checkbox"/> Send change to Delta Dental Date _____
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