Wespath
BENEFITS | INVESTMENTS

1901 Chestnut Avenue
Glenview, Illinois 60025-1604
wespath.org

Choose one: ❑ Enrollment ❑ Change HRA ❑ Terminate Coverage

Via Benefits Enrollment/Change Form

For newly eligible participants, please provide complete information on each eligible dependent. When making changes for enrolled participants, please provide only the information that has changed. Please ensure this form is sent at least 30 days prior and within 180 days of the intended effective date to ensure timely processing.

Part 1 – Participant/Plan Sponsor Information

Name _____ Participant # _____

Address _____ Primary phone # _____

_____ Alternate phone # _____

_____ E-mail address _____

Conference/Plan Sponsor/Employer(s) _____ Employer(s) # _____

_____

Membership: ❑ Clergy ❑ Lay

Appointment/Employment status _____ Status effective date _____

Part 2 – Processing Event

Please check the processing event below. Event effective date _____

❑ Newly eligible
❑ New dependent
❑ Retiree death
❑ Dependent death
❑ New retiree
❑ Retiree to active
❑ No longer eligible for Medicare Secondary Payer Small Employer Exception (MSPSEE)

Please list any special notes regarding the event:

_____

_____

_____

_____

_____

_____

Part 3 – Enrollment Information

- List new participant and all newly eligible dependents, including spouse, even if declining coverage. If participant is currently enrolled and adding/removing a dependent, list only that dependent's information.
- Indicate who will be covered in Via Benefits. ***Important:*** *If you do not choose "yes" or "no" under the* ***Cover*** *column for each dependent listed, we will assume you* ***do not*** *want to cover that dependent(s) in Via Benefits.*

Name	Birth Date	Relationship	Gender		Disabled		Cover		Annual HRA Amount*
			F	M	Yes	No	Yes	No	

*Via Benefits will prorate for partial year

For participants and spouses enrolled in Via Benefits: please qualify these individuals for the following well-being programs (plan sponsor must have elected this on Exhibits B and E):

- ❑ Personify Health®
- ❑ Blueprint for Wellness

Part 4 – Plan Sponsor Authorization

Plan sponsor signature _____ Date _____

If you are **NOT** completing this document online, please complete it and return to Wespath by one of the following methods:

- E-mail (scanned copy) to **activeteam@wespath.org** or
- Fax to **1-847-866-2724** or
- Mail to Wespath Benefits and Investments
  Active Benefits
  1901 Chestnut Avenue, Glenview, IL 60025

Be sure to keep a copy for your records.

This form includes and/or is requesting personally identifiable information (PII) and/or protected health information (PHI). You are encouraged to make elections and beneficiary designations online at **benefitsaccess.org**. When possible, managing your benefits online is the recommended approach to keep your PII and PHI safe and secure.