2015 Benefits Program Open Enrollment Form

IMPORTANT MEDICAL PLAN CHANGES FOR 2015

IMPORTANT: Form Must Be Returned To Human Resources, MS#15 by November 7, 2014. Please print clearly and complete all necessary sections in full.

PERSONAL INFORMATION

Last Name	First	WHOI ID#	Ext.

SECTION 1. HEALTH INSURANCE

OPTION 1: HIGH DEDUCTIBLE HEALTH PLAN with HEALTH REIMBURSEMENT ACCOUNT (HDHP-HRA) (BLUE CARE ELECT DEDUCTIBLE)

Please check one:

☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse/Domestic Partner ☐ Employee & Family ☐ Waive Coverage

If enrolling in the High Deductible Plan with HRA, you will automatically be enrolled in a WHOI funded Health Reimbursement Account which funds the first 50% of the annual deductible under this medical plan.

NOTE: Under this plan, you are also eligible to participate in a Health Care Flexible Spending Account (HC-FSA), which allows you to save pre-tax dollars to pay for out-of-pocket expenses under this plan. To enroll in the Health FSA, please complete Section 3.

OPTION 2: HIGH DEDUCTIBLE HEALTH PLAN with HEALTH SAVINGS ACCOUNT (HDHP-HSA) (BLUE CARE ELECT SAVER)

Please check one:

☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse/Domestic Partner ☐ Employee & Family ☐ Waive Coverage

If enrolling in the High Deductible Plan with Health Savings Account, you will automatically receive a WHOI contribution to your HSA account equal to 50% of the annual deductible under this plan. In addition to the WHOI contribution, you can also make your own voluntary pre-tax HSA contributions up to the annual IRS limits. The HSA annual limits for 2015 are $3,350 for single coverage, or $6,650 for family coverage. Plus, the IRS allows for an additional annual contribution of $1,000 for those age 55+ in 2015. The annual limits include the total combined employer and employee contributions.

If you wish to make your own voluntary pre-tax contributions to your HSA account for 2015 to begin with the first paycheck in 2015, please make your election below. Otherwise, you can elect or make changes to your HSA contribution at any time during the year.

HEALTH SAVINGS ACCOUNT (HSA)

☐ I elect to participate and would like to contribute $_____ per pay period beginning with my first paycheck in 2015.

NOTE: Under this plan, you are also eligible to participate in a "Limited Purpose" Flexible Spending Account (LP-FSA), which allows you to save pre-tax dollars to pay for vision and dental expenses only. To enroll in the "Limited Purpose" Health Care Flexible Spending Account, please complete Section 4.

SECTION 1. HEALTH INSURANCE (Continued…)

OPTION 3: LOW DEDUCTIBLE HEALTH PLAN (LDHP)
(ADVANTAGE BLUE)

Please check one:

☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse/Domestic Partner ☐ Employee & Family ☐ Waive Coverage

NOTE: Under this plan, you are also eligible to participate in a Health Care Flexible Spending Account, which allows you to save pre-tax dollars to pay for out-of-pocket expenses under this plan. To enroll in the Health Care Flexible Spending Account, please complete Section 3.

SECTION 2. DENTAL INSURANCE

Please check one:

☐ Already Enrolled ☐ Delta Dental Employee Only ☐ Delta Dental Employee & Family ☐ Waive Coverage

SECTION 3. HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HC-FSA) ELECTION

☐ I elect to participate ☐ Waive coverage

I elect to contribute $_____ per pay period x 27 pay periods for a total annual election of $_____

NOTE: minimum annual election $100/maximum $2,500. The HC-FSA is a benefit that needs to be re-elected each calendar year during the Open Enrollment period.

SECTION 4. "LIMITED PURPOSE" HEALTH CARE FLEXIBLE SPENDING ACCOUNT (LP-FSA) (for limited purpose vision & dental expenses only)

IMPORTANT: You may only participate in this plan if you are enrolled in the High Deductible Plan with Health Savings Account (HDHP-HSA)

☐ I elect to participate ☐ Waive coverage

I elect to contribute $_____ per pay period x 27 pay periods for a total annual election of $_____

NOTE: minimum annual election $100/maximum $2,500. The LP-FSA is a benefit that needs to be re-elected each calendar year during the Open Enrollment period.*

SECTION 5. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DC-FSA) / DEPENDENT CARE SUBSIDY

☐ I elect to participate

I elect to contribute $_____ per pay period x 27 pay periods for a total annual election of $_____

NOTE: minimum annual election $100/maximum $5,000. The DC-FSA is a benefit that needs to be re-elected each calendar year during the Open Enrollment period. Please see the Dependent Care Worksheet found in the Human Resources website to assist you in your election.

DEPENDENT CARE SUBSIDY

The Dependent Care Subsidy benefit, paid by WHOI, is in addition to the DC-FSA

☐ I elect to participate

NOTE: If you enroll in the DC-FSA and /or DC-Subsidy program(s), you will receive a separate informational packet.

SECTION 6. DEPENDENT ENROLLMENT INFORMATION: CHECK *ONLY IF* YOU ARE ADDING A DEPENDENT, REMOVING A DEPENDENT, OR CHANGING A DEPENDENT.

Please attach a separate sheet for additional dependents.

Add	Remove	Change	Name	SSN	DOB	Sex	Relation	MEDICAL	DENTAL	DCAP/ SUBSIDY
☐	☐	☐						☐	☐	☐
			☐ Spouse ☐ Domestic Partner* ☐ Ex-Spouse							
☐	☐	☐						☐	☐	☐
			☐ Dependent of Employee ☐ Dependent of Domestic Partner*							
☐	☐	☐						☐	☐	☐
			☐ Dependent of Employee ☐ Dependent of Domestic Partner*							
☐	☐	☐						☐	☐	☐
			☐ Dependent of Employee ☐ Dependent of Domestic Partner*							

Affidavits are required for Domestic Partner coverage; please refer to HR Web Site
http://www.whoi.edu/fileserver.do?id=33863&pt=2&p=32432

IMPORTANT TAX INFORMATION

As a participant in WHOI's medical and /or dental benefits, you may enroll a variety of eligible family members for coverage including your Spouse/Ex-Spouse/Domestic Partner (same or opposite sex). In addition, your dependent children, as well as those of your Spouse/Domestic Partner, are also eligible for coverage. Your plan covers dependents through the end of the month in which they turn age 26. For more information, go to our Family Coverage page on the Human Resources web site. Contributions for the health and dental insurance will automatically default to pre-tax.

***Please Note:** Domestic Partner/Ex-Spouse and dependent coverage may be subject to after tax deductions and imputed income.*

SECTION 7. EMPLOYEE APPROVAL

I understand that the above elections are effective for the calendar year 2015 and may not be changed during the plan year unless I experience a Qualifying Event as defined by the IRS and supply the Human Resource Office with the necessary documentation within 30 days of said event. I agree to abide by the regulations and terms of the plans I have enrolled in according to the summary plan descriptions for each plan. I authorize the plan administrator (Woods Hole Oceanographic Institution) to deduct from my paycheck all appropriate premiums for my elections. I confirm that the information listed above is true and accurate. (Please retain a copy for your records.)

_____ _____

Employee Signature *Date*

Reviewed By:

Initials _____

Date Reviewed _____