

Instructions on how to complete the electronic Open Enrollment Form

The Open Enrollment form is accessed through Employee Online (where you access your paycheck stubs) - [Employee Online](#)

Please note: You must not be blocking pop-ups when filling out this form. This form works on many browsers including Internet Explorer, Firefox, Chrome and Safari.

Step 1: Select **“Open Enrollment”** in Employee Online to process your benefits form.

Finance Dashboard

W. H. O. I. (Prod)

Employee Online

- EO Home
 - Message Page
 - Employee Directory
- Personal Information
 - Home Address
 - Emergency Info
- Pay Information
 - Direct Deposit
 - Check Stub
 - Tax Info
 - W2 Info
 - W2 Consent
- Job Information
 - Current Job
 - Education
- Benefits**
 - Open Enrollment**
 - Insurance
 - Term Life Insurance
 - Family Info

Welcome

THIS IS A TEST
Welcome to the Employee Online web site. This site provides a way for you to keep your payroll information up to date.
Please feel free to browse your current payroll setup and make changes as needed.
Next payday will be 11/2/2018. Requests made in Employee Online prior to midnight 10/26/2018 will be considered for the check of 11/2/2018.

Instructions

Step 1: Choose an area
Select the tab for the area with the information that you want to change.

Step 2: Select the record that you would like to modify.
Choose the record you would like to modify.

Step 3: Submit request
Click on the button to submit your request.

Step 4: Repeat as needed.
Repeat the process in other areas of Employee Online as needed.

Step 2: When you initially select the Open Enrollment Form from Employee Online you will see your Name and ID number at the top of the form. If you do not see your name and employee ID contact Human Resources at extension 2253. If your information has populated, continue to the next step.

Step 3: Before you begin, please click the “Load Current Coverage” button. This will load your current benefit coverage elections into the form.

→ **2019 Open Enrollment Benefits Election Form**

Important: The deadline to submit this form is November 16, 2018

EMPLOYEE NAME:	Employee name	WHOI ID#:	ID #	F EX
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INSTRUCTIONS

Before you begin, please click the 'Load Current Coverage' button below to load your current benefit elections into the form. Review each benefit election below and make changes as needed. Please note that you must re-enroll in the Flexible Spending Accounts each year.

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REVIEW DEPENDENT INFORMATION

Any changes to dependent information must be identified in the "[Notes to HR / Approver](#)" section, in addition to making the applicable changes on Employee Online. Before you begin making your Open Enrollment benefit elections, go to the Employee Online Family Screen, and complete the name, relationship, date of birth, social security number and gender of all eligible dependent(s) you wish to add and/or update. Review each dependent to ensure they continue to be eligible for coverage and remove any dependent(s) that are no longer eligible. WHOI reserves the right to conduct dependent eligibility verification at any time.

Eligible dependents include your:

- Legal Spouse (same or opposite gender);
- Domestic Partner* (same or opposite gender);
- Child(ren), including your Domestic Partner's child(ren), up to age 26

*** IMPORTANT INFORMATION REGARDING DOMESTIC PARTNERS:**
Each year, you must complete the Domestic Partner Affidavit and submit the supporting documentation to HR before coverage for a Domestic Partner or their eligible dependents can begin. To obtain the Domestic Partner Affidavit and the Domestic Partner Guidelines, including a list of acceptable documents, please visit the Benefits website at:
<http://www.whoiedu/HR/page.do?pid=46820>

MEDICAL INSURANCE
Review and select one (1) option from each column below.

Step 4: A pop up will present you with your current coverage. You will be able to change these options as you fill out the form.

Click **close** to continue.

Loaded Benefit Data

Medical Insurance:	Coverage Waived
Dental Insurance:	Delta Dental EE Only
Vision Insurance:	Vision EE Only
Basic Life Insurance:	1.5x Salary
Supplemental Life & ADD	
Employee:	No current coverage found.
Spouse/Domestic Partner:	Coverage Waived
Child(ren):	Coverage Waived

Close

Step 5 – Medical Plan: Select a Medical Plan and Coverage Level. (ex: Blue Care Elect Deductible with HRA and Employee Family)
If you do not wish to enroll in a Medical Plan, be sure to select the **“Waive Coverage”** option.

MEDICAL INSURANCE	
Review and select one (1) option from each column below.	
MEDICAL PLAN	COVERAGE LEVEL
<p><input checked="" type="radio"/> Blue Care Elect Saver (with HSA) <i>With this plan, you will receive a bi-weekly WHOI contribution to a Health Savings Account (HSA) to offset the annual deductible. You may also contribute pre-tax funds to the HSA, up to IRS limits. You cannot elect this plan if you are enrolled in Medicare.</i></p> <p><input type="radio"/> Blue Care Elect Deductible (with HRA) <i>With this plan, you will receive a WHOI funded Health Reimbursement Account (HRA) to offset the annual deductible.</i></p> <p><input type="radio"/> Advantage Blue (Low Deductible Plan)</p> <p><input type="radio"/> Waive Coverage</p>	<p><input type="radio"/> Employee Only</p> <p><input type="radio"/> Employee & Child(ren)</p> <p><input type="radio"/> Employee & Spouse / Domestic Partner</p> <p><input type="radio"/> Employee & Family (with Spouse / Domestic Partner)</p>

Step 5a – Healthcare Savings Account (if applicable): If you elect to participate in the **Blue Care Elect Saver (with HSA)** an additional box will appear. You will need to indicate an amount that you would like to contribute per pay period. If you wish to contribute the Maximum amount, please click the “Max” button.

HEALTHCARE SAVINGS ACCOUNT
For Blue Care Elect Saver Participants Only

If you wish to make your own voluntary pre-tax contributions to your HSA account for 2019, please make your election below. You can also elect or make changes to your HSA contribution at any time during the year.

I elect to contribute \$ per pay period x 26 pay periods for a total annual election of \$ 

Note: You cannot enroll in Blue Care Elect Saver or the HSA if you are enrolled in Medicare.

The HSA annual limits for 2019 are \$3,500 for single coverage, or \$7,000 for family coverage. Plus, the IRS allows, for an additional annual contribution of \$1,000 for those age 55+ in 2019. The annual limits include the total combined employer and employee contributions. The HSA does not require a qualified event to make a change during the year.

*** Under this plan, you are also eligible to participate in the Limited Purpose Flexible Spending Account (LPFSA), which allows you to save pre-tax dollars to pay for vision and dental expenses only. To enroll in the LPFSA make your selection in the next section.

Step 5b – Limited Purpose Healthcare Flexible Spending Account (if applicable): If you elect to participate in the **Blue Care Elect Saver (with HSA)** an additional box for the Limited Purpose Flexible Spending Account (LPFSA) will appear. If you would like to enroll in the LPFSA, indicate the amount that you would like to contribute per pay period. *Please note the Limited Purpose Healthcare Flexible Spending Account is for Vision and Delta expenses only.* If you wish to contribute the Maximum amount, please click the “Max” button.

LIMITED PURPOSE HEALTHCARE FLEXIBLE SPENDING ACCOUNT (LPFSA)
(for Vision & Dental expenses only)

Waive Coverage

I elect to participate

I elect to contribute \$ per pay period x 26 pay periods for a total annual election of \$ 

Note: Minimum annual election \$100 / maximum \$2,700.
The LPFSA is a benefit that needs to be re-elected each year during Open Enrollment.

Step 6 – Health Care Flexible Spending Account (if applicable): Next you will need to indicate whether or not you would like to participate in the Health Care Flexible Spending Account. To elect to participate, click the **“I elect to participate”** radio button and enter the amount per pay period you would like to contribute. *Please note the Minimum **annual** election is \$100.00 and the Maximum **annual** election is \$2,700.*

*Please also note that you are **not** eligible to participate in the Health Care Flexible Spending Account if you elect to participate in the Blue Care Elect Saver (with HSA) Medical Plan. If you elect the HSA Medical Plan, the Health Care Flexible Spending Account option will not appear as an option on your Benefits Election Form.*

If you would **not** like to participate in the Health Care Flexible Spending Account, please click on the **“Waive Coverage”** radio button. If you wish to contribute the Maximum amount, please click the **“Max”** button.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (HCFSA)
Review and select one (1) option below.

Waive Coverage

I elect to participate

I elect to contribute \$ per pay period x 26 pay periods for a total annual election of \$

*Note: Minimum annual election \$100 / maximum \$2,700.
The HCFSA is a benefit that needs to be re-elected each year during Open Enrollment.*



Step 7 – Dental Plan: Select a Dental Plan. If you do not wish to enroll in a Dental Plan, be sure to select the **“Waive Coverage”** option.

DENTAL INSURANCE
Review and select one (1) option below.

Waive Coverage

Employee Only

Employee & Child(ren)

Employee & Spouse / Domestic Partner

Employee & Family (Spouse / Domestic Partner)

Step 8 – Vision Plan: Select a Vision Plan.
If you do not wish to enroll in a Vision Plan, be sure to select the “**Waive Coverage**” option.

VISION INSURANCE
Review and select one (1) option below.

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

Step 9-Dependent Care Flexible Spending Account: Next you will need to indicate whether or not you would like to participate in the Dependent Care Flexible Spending Account. To elect to participate, click the “**I elect to participate**” radio button and enter the amount per pay period you would like to contribute. *Please note the Minimum **annual** election is \$100.00 and the Maximum **annual** election is \$5,000.*

If you would **not** like to participate in the Dependent Care Flexible Spending Account, please click on the “**Waive Coverage**” radio button.
If you wish to contribute the Maximum amount, please click the “**Max**” button

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)
(for children under age 13)

- Waive Coverage**
- I elect to participate**

I elect to contribute \$ per pay period x 26 pay periods for a total annual election of \$ ←

*Note: Minimum annual election \$100 / maximum \$5,000.
The DCFSA is a benefit that needs to be re-elected each year during Open Enrollment.*

Step 10 – Dependent Care Subsidy: Please indicate if you would like to participate in the Dependent Care Subsidy by clicking on the “I elect to participate” radio button. Otherwise, click on the “Waive Coverage” radio button.

DEPENDENT CARE SUBSIDY (DCS)

(for children under age 13)

- Waive Coverage
- I elect to participate

NOTE: If you enroll in the Dependent Care Subsidy program, you will receive a separate information packet.

Step 11 – Basic Life Insurance: Please indicate whether you would like to elect WHOI provided basic life insurance at 1.5 x your salary, or limit your coverage to \$50,000. Be sure to read the full description prior to electing.

Please note if you are an Employee in a Temporary status, you are not eligible to participate in Life Insurance.

BASIC LIFE INSURANCE

WHOI provides Basic Life Insurance equal to 1.5 times your base annual salary (e.g., full-time, 3/4-time, or 1/2-time salary), up to a maximum of \$400,000. Per IRS regulations, the premium cost for life insurance coverage over \$50,000 is taxable as imputed income to the employee.

Employees wishing to avoid any imputed income tax can elect to limit their coverage to \$50,000.

Please check one:

- 1.5x Salary
- Limit coverage to \$50,000

Step 12 – Supplemental Life Insurance: You may elect to purchase additional life insurance for you and your eligible dependents. If you wish to enroll in supplemental life for yourself, your spouse, and/or your child(ren), please indicate the levels of coverage below. Please be aware that the coverage level selected may require you to complete Evidence of Insurability (EOI) to the insurance carrier before coverage is effective. **Please note if you are an Employee in a Temporary status, you are not eligible to participate in Life Insurance.**

Please be sure to read the notes on the form regarding Guaranteed Issue (GI) and Evidence of Insurability (EOI).

SUPPLEMENTAL LIFE & ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

You may elect to purchase additional life insurance for you and your eligible dependents. Your premiums for supplemental life and AD&D coverage is paid through payroll deductions on an after-tax basis and is not subject to imputed income. If you wish to enroll in supplemental life insurance, please make your elections below. Please be aware that your coverage may require you to submit Evidence of Insurability (EOI) information to the insurance carrier before coverage is effective.

Employee Life Insurance *	
<input type="radio"/>	Waive Coverage
<input type="radio"/>	1x
<input type="radio"/>	2x
<input type="radio"/>	3x
<input type="radio"/>	4x

Spouse / Domestic Partner Life Insurance * (Spouse / Domestic Partner to age 70)
Make a Selection ▼
Election may be made in \$10,000 increments up to \$250,000 max

Child Life Insurance (Children to age 26)	
<input type="radio"/>	Waive Coverage
<input type="radio"/>	\$5,000
<input type="radio"/>	\$10,000

Guarantee Issue (GI) and Evidence of Insurability Information

You may elect to participate in the Supplemental Life Insurance plans up to the guaranteed issue amounts listed below. If you elect more than the guarantee issue amount, the additional amount will be subject to Evidence of Insurability (EOI) with the insurance carrier. The amount of your coverage that will be in effect and that your premiums will be based on will be the GI limit and upon receipt of your EOI approval from the insurance carrier, an adjustment will be made.

Employee:

Guaranteed coverage amount is the lesser of 3 times annual salary or \$250,000. The maximum benefit is the lesser of 4 times annual salary or \$500,000. Coverage is reduced beginning at age 65.

Spouse/Domestic Partner:

Guaranteed coverage amount is \$30,000. Increments of \$10,000 to a maximum of \$250,000. Coverage is reduced beginning at age 65.

If you are increasing or electing coverage outside of your initial eligibility, or the amount exceeds \$30,000 for Spouse Life coverage, or the lessor of 3 times annual salary, or \$250,000 for Employee Supplemental coverage, you will need to complete an Evidence of Insurability (EOI) by visiting www.MyLibertyConnection.com. Use Customer Code: WHOI.

For questions related to EOI, please contact Liberty Mutual directly at 800-287-8494

NOTE: The employee is automatically the beneficiary for Spouse and Child Life Insurance.

*Costs subject to change with changes in age and/or salary.

Step 13 – Notes & Employee Consent: Use this space to add any comments or questions for HR.

Once you are ready to submit, type your initials as your digital signature. Before hitting submit, click the **“Print Form”** button to print a copy of your elections for your records. You can then click on Submit.

NOTES TO HR / APPROVER
150 Character Max

Please be sure to add comments below for any changes to your dependents. Also, you may use the space below for other comments and questions for HR.

EMPLOYEE CONSENT

I wish to make the choices entered on this form. I authorize the Woods Hole Oceanographic Institution (WHOI) to reduce my compensation by the amounts required for the coverage I have elected. I understand that these elections replace any previous elections. I understand that my elections cannot be changed, with the exception of the HSA and DCS, unless I experience as Qualified Life Event, as defined under the Internal Revenue Service (IRS), and the change in coverage is caused by and consistent with the Qualified Life Event, and I notify and provide Human Resources the appropriate supporting documentation within 31 days of said event.

Should my employment terminate or I become ineligible for the Plans, I understand my Medical, Dental, Vision, HCFSA and/or LPFSA elections will end on the last day of the month in which I terminate or are no longer eligible and that payroll deductions will continue through my last pay check. Life, Disability and Dependent Care FSA elections will end on the last day of active employment or eligibility. I certify, to my knowledge, that all information provided herein is accurate. I further understand that false or inaccurate information, including information related to the eligibility of my dependents, may result in the termination of coverage, nonpayment of benefits, or other disciplinary action up to and including termination of employment. In the event of a discrepancy between the information provided herein and the official Plan Documents, the Plan Documents will govern.

Please retain a copy for your records.

Type Your Initials as Electronic Signature Required 

Before you click [Submit](#) to send this form, print a copy for your records.