FORM MUST BE RETURNED TO HUMAN RESOURCES BY 30 DAYS FROM ELIGIBILITY DATE

2015 BENEFITS PROGRAM ENROLLMENT / CHANGE FORM

(FOR BENEFITS ELIGIBLE EMPLOYEES WORKING 20+ HOURS PER WEEK)

Please print clearly and complete all necessary sections in full. Your benefits enrollment form must be completed even if you are waiving coverage in the WHOI benefits. Please return the completed form to the Human Resources Office, MS#15 ***within 30 days from your eligibility / qualifying event date****.*

PLEASE CHECK APPROPRIATE BOX:

☐ **New Hire** ☐ **Status Change** ☐ **Marriage** ☐ **Birth/Adoption** ☐ **Divorce** ☐ **Loss of Coverage**

PERSONAL INFORMATION

Last Name: **First Name:** **WHOI ID#:** **Ext.:**

SECTION 1. HEALTH INSURANCE (3 PLANS TO CHOOSE FROM)

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: For mid-year enrollments, the HRA contribution is pro-rated based on the month you are enrolling in the 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, that are not paid by the HRA . 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. NOTE: For mid-year enrollments, the HSA is pro-rated based on the month you are enrolling in the 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 ages 55+ in 2015. These limits are inclusive of both employer and employee contributions.

IMPORTANT: the IRS imposes strict rules on the amount of HSA contributions that can be made in a given year based on the number of months enrolled in a qualified high deductible health plan. For example, if you are covered by a qualified plan for only 6 months of the year, you are only allowed to make pro-rated HSA contributions based on the number of months you are enrolled in the qualified medical plan.

If you wish to make your own voluntary pre-tax contributions to your HSA account, 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 in 2015 to be deducted on a per pay period basis based on the number of pay periods remaining 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 (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.

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

Minimum annual contribution of $100 and maximum of $2,500. Elections are irrevocable and cannot be changed during the year unless you experience a qualified life event as defined by the IRS that allows you to make a change.

I elect to participate in the HC-FSA and would like to contribute $_____annually in 2015 to be deducted on a per pay period basis based on the number of pay periods remaining in 2015.

NOTE: 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

Minimum annual contribution of $100 and maximum of $2,500. Elections are irrevocable and cannot be changed during the year unless you experience a qualified life event as defined by the IRS that allows you to make a change.

I elect to participate in the Limited Purpose HC-FSA and would like to contribute $_____annually in 2015 to be deducted on a per pay period basis based on the number of pay periods remaining in 2015.

NOTE: The Limited Purpose HC-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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT:

☐ I elect to participate in the Dependent Care FSA and would like to contribute $_____annually in 2015 to be deducted on a per pay period basis based on the number of pay periods remaining in 2015.

Minimum annual election $100/maximum $5,000. Elections are irrevocable and cannot be changed during the year unless you experience a qualified life event as defined by the IRS that allows you to make a change.

NOTE: 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 from Human Resources

SECTION 6. LIFE INSURANCE / AD&D

Basic Life Insurance (paid for by WHOI)

WHOI provides Basic Life Insurance equal to one times your base annual salary (e.g., full-time, ¾-time, or ½-time salary). 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 waive their coverage to $50,000.

Please check one:

☐ 1x Salary

☐ Limit coverage to $50,000

Supplemental Life/AD&D Insurance (voluntary coverage paid by Employee)

Employee Life Coverage*	Spousal Life Coverage*	Child Life Coverage	AD&D Coverage
☐ 1x Salary ☐ 2x Salary ☐ 3x Salary ☐ 4x Salary ☐ Waive Coverage	Coverage $_____ Election may be made in $5,000 increments up to $100,000 max ☐ Waive Coverage	☐ $2,000 ☐ $5,000 ☐ Waive Coverage Age Limits: children under age 19 or 19-25 if a full-time student	☐ Individual ☐ Family Coverage $_____ ☐ Waive Coverage

The Guaranteed issue amount is the lessor of 3 times Annual Compensation or $ 250,000. The Maximum Benefit is the lesser of 4 times Annual Compensation or $ 400,000.
If you are increasing or electing coverage outside of your initial eligibility, or the amount exceeds $30,000 for spousal coverage, $250,000 for employee coverage, or 3 times Annual Compensation, you will need to complete an Evidence of Insurability (EOI) form. Please contact your Benefit Specialist for details.

Please complete the Beneficiary Designation section below. NOTE: if spousal and/or child coverage is elected, the employee is automatically the beneficiary of the benefit.

Life Insurance Beneficiary Designation

Primary Beneficiary

Name	SSN	Relationship	% of Share

Contingent Beneficiary

Name	SSN	Relationship	% of Share

SECTION 7. DEPENDENT ENROLLMENT INFORMATION
COMPLETE *ONLY IF* YOU ARE ADDING, REMOVING, 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 the HR website for further information at** http://www.whoi.edu/fileserver.do?id=33863&pt=2&p=32432

IMPORTANT TAX INFORMATION

As a participant in WHOI's health 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 to age 26. For more information, please refer to the Family Coverage page on the Human Resources website at http://www.whoi.edu/HR/page.do?pid=21575. 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 8. EMPLOYEE APPROVAL

I understand that the above elections are effective for the calendar year 2014 and may not be changed during the plan year unless I experience a Qualifying Life Event as defined by the IRS and supply the Human Resource Office with the necessary supporting 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 description 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*

SECTION 9. HUMAN RESOURCES APPROVAL

Reviewed by:

Initials _____

Date Reviewed _____