Reviewed by HR:
Initial: _____
Date: _____

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

2012 BENEFITS PROGRAM ENROLLMENT/CHANGE FORM

FOR BENEFITS ELIGIBLE EMPLOYEES WORKING 20+ HOURS PER WEEK

Please print clearly and complete all necessary sections in full. Form must be completed even if you are waiving coverage in the WHOI benefits. In addition, if you are waiving medical coverage, you are required to complete a separate HIRD Form. 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** ☐ **Marriage** ☐ **Birth/Adoption** ☐ **Divorce** ☐ **Loss of Other Coverage**

PERSONAL INFORMATION					
Last Name	First Name		MI	DOB	WHOI ID#
Address	City	State	Zip	Gender: ☐ Male ☐ Female	Home Phone #
Hire Date/Event Date	Dept.	MS#		Office Ext.	

SECTION 1: HEALTH INSURANCE			
Health Plan Election (Please check one)	***Coverage Level (Please check one)***	**PCP Election for HMO Required**	
☐ **Waive Coverage ***	☐ **Employee Only**	PCP#	
☐ **HDHP with HRA****	☐ **Employee + Child(ren)**	PCP Name	
☐ **HMO New England**	☐ **Employee + Spouse/Ex-Spouse**	PCP#	
☐ **Access Blue**	☐ **Employee + Same Sex Spouse**	PCP Name	
☐ **Blue Care Elect – PPO**	☐ **Employee + Domestic Partner**	PCP#	
Blue Care Elect PPO is for out of state employees only.	☐ **Employee + Family**	PCP Name	
****If waiving coverage you MUST complete the separate Employee Health Insurance Responsibility Form (HIRD Form)***		PCP information can be found at www.bcbsma.com	
***If enrolling in the HDHP, you will automatically be enrolled in a WHOI funded Heath Reimbursement Account and will receive further information on the HRA under separate cover.*			

SECTION 2: DENTAL INSURANCE			
Dental Plan Election (Please check one)		***Coverage Election (Please check one)***	
☐ **Delta Dental Premier**	☐ **Waive Coverage**	☐ **Employee Only**	☐ **Employee + Family**

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 to age 26. For more information, go to our Open Enrollment site.

Contributions for the health and dental insurance will automatically default to pre-tax. ***Please Note:*** *Same Sex Spouse/Domestic Partner/Ex-Spouse and dependent coverage may be subject to after tax deductions and imputed income.*

IMPORTANT: Complete all dependent information (Section 6 of this form) if you are enrolling in coverage other than employee only.

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

MUST RE-ENROLL EACH YEAR TO PARTICIPATE

☐ **Waive Coverage** ☐ **I elect to participate:** Annual Election $_____ (minimum annual election $100/maximum $5,000)

IMPORTANT: To enroll in this benefit, you must also complete the separate Benefit Strategies Enrollment Form.

Pre-tax deductions will be taken evenly over the number of pay periods in the year from your enrollment date. The HC-FSA is a benefit that needs to be re-elected each calendar year during Open Enrollment.

SECTION 4: DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DC-FSA) / DEPENDENT CARE SUBSIDY

MUST RE-ENROLL EACH YEAR TO PARTICIPATE

4a. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DC-FSA)

☐ **Waive Coverage** ☐ **I elect to participate:** Annual Election $_____ (minimum $100 / maximum $5,000)

Pre-tax deductions will be taken evenly over the number of pay periods in the year from your enrollment date. The DC-FSA is a benefit that needs to be re-elected each calendar year during Open Enrollment. Please see the Dependent Care Worksheet found on the Human Resources web site to assist you in your election.

4b. DEPENDENT CARE SUBSIDY

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

☐ **Waive Coverage** ☐ **I elect to participate**

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

SECTION 5: LIFE INSURANCE/AD&D

A. Basic Life Election *(paid for by WHOI)*

☐ **1 X Salary** (Automatically provided by the employer; or employee can limit coverage to $50,000 to avoid imputed income tax)

☐ **$50,000** (IRS regulations state that the premium for basic life coverage over $50,000 is taxable to the employee)

B.* Supplemental Life Election *(coverage costs are paid fully by the employee)

If you are increasing or electing coverage outside of your initial eligibility, or the amount exceeds $30,000 for spousal coverage, you will need to complete an Evidence of Insurability (EOI) form. Please contact your Benefit Specialist for details. If spousal and/or child coverage is elected, the employee is automatically the beneficiary of the benefit.

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

Life Insurance Beneficiary Designation

Primary Beneficiary

Name	SSN	Relationship	% of Share

Contingent Beneficiary

Name	SSN	Relationship	% of Share

**If you are increasing/electing coverage outside your initial eligibility, you will need to complete an Evidence of Insurability Form. Please contact your Benefits Specialist.*

**If spousal and/or child coverage is elected, the employee is the automatic beneficiary of the benefit.*

SECTION 6: DEPENDENT ENROLLMENT INFORMATION

Affidavits are required for Domestic Partner coverage. See our Open Enrollment site for affidavit.

CHECK ALL THAT APPLY:

Add	Remove	Change	Name	SSN	DOB	Sex	Relation	PCP# (HMO)	Health	Dental	DC-FSA/DCS
☐	☐	☐							☐	☐	☐
			☐ **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**								
☐	☐	☐							☐	☐	☐
			☐ **Dependent of Employee** ☐ **Dependent of Domestic Partner**								
☐	☐	☐							☐	☐	☐
			☐ **Dependent of Employee** ☐ **Dependent of Domestic Partner**								

SECTION 7: EMPLOYEE APPROVAL

I understand that the above elections are effective for the calendar year 2012 and may not be changed during the plan year unless I experience a Qualifying Event as defined by the IRS and supply the Benefits 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