FORM MUST BE RETURNED TO HUMAN RESOURCES WITHIN 31 DAYS FROM ELIGIBILITY DATE

2017 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 31 days from your eligibility/Qualifying Event Date****.*

PLEASE CHECK APPROPRIATE BOX: **Qualified Life Event Date:** _____

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

PERSONAL INFORMATION

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

SECTION 1: MEDICAL INSURANCE (3 PLANS TO CHOOSE FROM)

Option 1: Blue Care Elect Deductible (with Health Reimbursement Account (HRA))

With this plan you will receive a WHOI funded HRA to offset the annual deductible.

Please check one:

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

If enrolling in the Blue Care Elect Deductible plan, you will receive a WHOI funded HRA up to 50% of the annual deductible under this plan. The HRA is prorated for New Hires and mid-year enrollments.

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

Option 2: Blue Care Elect Saver (with Health Savings Account (HSA))

With this plan you will receive a ***bi-weekly*** *WHOI contribution to an HSA to offset the annual deductible. See below for additional information. You cannot elect this plan if you are enrolled in Medicare.*

Please check one:

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

If enrolling in the Blue Care Elect Saver plan, you will receive a bi-weekly WHOI contribution to your HSA account up to 50% of the annual deductible under this plan. The HSA is prorated for New Hires and mid-year enrollments. In addition to the WHOI contribution you are eligible to make your own pre-tax HSA contributions up to the annual IRS limits. The HSA annual limits for 2017 are $3,400 for single coverage or $6,750 for employee plus dependent(s) coverage, less the WHOI contribution. Plus, the IRS allows for an additional annual contribution of $1,000 for those ages 55+ by the end of the calendar year. The annual limits include both employer and employee contributions. You may change your HSA contributions at any time as they do not require a Qualified Life Event to make a change.

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 contribute more than these limits, you will receive a 1099 directly from Health Equity.

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.

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

Health Savings Account (HSA)

☐ I elect to participate in the HSA and would like to contribute $_____ **per pay period** to be deducted on a per pay period basis for remainder of this year.

NOTE: Under this plan, you are also eligible to participate in a 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, please complete Section 4.

SECTION 1: MEDICAL INSURANCE (Continued)

Option 3: Advantage Blue (Low Deductible Plan)

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 Healthcare Flexible Spending Account (HCFSA), which allows you to save pre-tax dollars to pay for out-of-pocket expenses under this plan. To enroll in the HCFSA, please complete Section 3.

SECTION 2: DENTAL INSURANCE

Please check one:

☐ Keep Current ☐ Delta Dental Employee Only ☐ Delta Dental Employee & Family ☐ Waive Coverage

SECTION 3: HEALTHCARE FLEXIBLE SPENDING ACCOUNT (HCFSA)

☐ I elect to participate ☐ Waive coverage

Minimum annual contribution of $100/maximum $2,600. 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 HCFSA and would like to contribute $_____ **annually** to be deducted on a per pay period basis based on the number of pay periods remaining this year.

NOTE: The HCFSA is a benefit that needs to be re-elected each calendar year during the Open Enrollment period.

SECTION 4: LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (LPFSA) (for those in the Blue Care Elect Saver plan)

IMPORTANT: You may only participate in this plan if you are enrolled in the Blue Care Elect Saver Medical Plan with (HSA).

☐ I elect to participate ☐ Waive coverage

Minimum annual contribution of $100/maximum $2,600. 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 LPFSA and would like to contribute $_____ **annually** to be deducted on a per pay period basis based on the number of pay periods remaining this year.

NOTE: The LPFSA is a benefit that needs to be re-elected each calendar year during the Open Enrollment period.

SECTION 5. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA) & DEPENDENT CARE SUBSIDY (DCS)

Dependent Care Flexible Spending Account (DCFSA):

☐ I elect to participate ☐ Waive coverage

Minimum annual election of $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.

I elect to participate in the DCFSA and would like to contribute $_____ **annually** to be deducted on a per pay period basis based on the number of pay periods remaining this year.

NOTE: The DCFSA is a benefit that needs to be re-elected each calendar year during the Open Enrollment period.

DEPENDENT CARE SUBSIDY (DCS):
The DCS benefit, paid by WHOI on an after-tax basis, is in addition to the DCFSA. You enroll in the DCS benefit at any time as this benefit does not require a Qualified Life Event to make a change.

☐ I elect to participate ☐ Waive coverage

Note: If you enroll in the DCS program you will receive a separate informational packet.

SECTION 6. LIFE INSURANCE / AD&D INSURANCE

Basic Life Insurance (paid 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 elect to limit their coverage to $50,000.

Please check one:

- ☐ 1x Salary
- ☐ Limit coverage to $50,000

Supplemental Life and 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 to age 26	☐ Individual ☐ Family Coverage $_____ ☐ Waive Coverage

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 $400,000.

Spouse/Domestic Partner: Increments of $5,000 to a maximum of $100,000. Guaranteed coverage amount is $30,000.

If you are increasing or electing coverage outside of your initial eligibility, or the amount exceeds $30,000 for spouse coverage, or $250,000 for employee coverage, or 3 times annual salary for employee coverage, you will need to complete an Evidence of Insurability (EOI) form. Please contact Cigna directly at 800-362-4462.

Please complete the Beneficiary Designation section below. NOTE: If spouse/domestic partner and/or child coverage is elected, the employee is automatically the beneficiary of the benefit.

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

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*							
☐	☐	☐						☐	☐	☐
			☐ Dependent of Employee ☐ Dependent of Domestic Partner*							
☐	☐	☐						☐	☐	☐
			☐ Dependent of Employee ☐ Dependent of Domestic Partner*							
☐	☐	☐						☐	☐	☐
			☐ Dependent of Employee ☐ Dependent of Domestic Partner*							

You must submit an Affidavit of Domestic Partnership with supporting documentation before coverage can be effective. For more information, please visit the Benefits website.

IMPORTANT TAX INFORMATION

As a participant in WHOI's benefit plans, you may enroll a variety of eligible dependents including your legal spouse, domestic partner, eligible dependent child(ren), and your domestic partners eligible child(ren). WHOI's plans cover eligible dependent child(ren) through the end of the month in which they turn age 26. For more information, please refer to the Eligible Dependents page on the Benefits website. Contributions for benefit plans governed by Section 125 including Medical, Dental, FSA, and HSA will be deducted on a pre-tax basis. Other benefits, such as Supplemental Life Insurance plans will be deducted on an after-tax basis.

Please Note: Coverage for Domestic Partner and their eligible dependents will be subject to after-tax deductions and Imputed Income.

SECTION 8: HR USE ONLY

I wish to make the choices entered on this form. I authorize Woods Hole Oceanographic Institution (WHOI) to reduce my compensation by the amounts required for the coverage I have elected. 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), occurs and the change in coverage is caused by and consistent with the Qualified Life Event and I notify and provide HR with the supporting documentation within 31 days of said event.

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

Arbitration Agreement: I understand that any dispute of controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of this agreement between myself (and/or any enrolled eligible dependent) and the insurance carriers, or any Participating Medical Group/Independent Physicians association, whether arising in a contract, tort or otherwise, must be submitted to arbitration in lieu of jury court trial.

Please retain a copy for your record.

_____ _____

Employee Signature Date

SECTION 9. FOR HR USE ONLY:

Reviewed by: _____ Date Received: _____