



2007 MEDICAL BENEFITS ONLY ENROLLMENT FORM

Joint Program Students/Post Doc Fellows and Scholars

Please print clearly and complete all necessary sections in full. If you are not making any changes during Open Enrollment, you do not need to complete the form. Please return the completed form to the Human Resources Office, MS#15, by November 13, 2006 for January 1, 2007 effective date, or within 30 days from eligibility date.

Please check the appropriate box: Open Enrollment New Hire Other (please list) _____

SECTION 1: PERSONAL INFORMATION

Name _____ SSN _____ Employee ID _____ Male Female
Last First MI
Street _____ City _____ State _____ Zip Code _____
DOB _____ Hire Date _____ Dept. # _____ MS# _____ Ext. _____

SECTION 2: HEALTH INSURANCE

Health Plan Election (please check one)

- HMO New England (Enhanced Value)
- Access Blue (Enhanced Value)
- Blue Care Elect – PPO (Enhanced Value)
- Waive Coverage

Coverage Election (please check one)

- Employee Only
- Employee + Child
- Employee + Spouse
- Employee + Same Sex Spouse
- Employee + Domestic Partner
- Employee + Family

PCP Election for HMO Required:

PCP # _____

PCP Name _____

(PCP information can be found at www.bcbsma.com)

Effective January 1, 2007, as a participant in WHOI benefits, you may enroll a variety of eligible family members for coverage. This now includes your 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. For more information, go to <http://www.whoi.edu/services/HR/benefits/OE/index>.

* **Please Note:** Same Sex Spouse/Domestic Partner coverage may be subject to after tax deductions and imputed income.
* Complete all dependent information (section 3 of this form) if you are enrolling in coverage other than employee only.

SECTION 3: DEPENDENT ENROLLMENT INFORMATION

(check all that apply)

Name	SSN	DOB	Sex	Relation	PCP# (HMO)
Spouse <input type="checkbox"/>	or	Domestic Partner <input type="checkbox"/>			
Dependent of Employee <input type="checkbox"/>	or	Dependent of Domestic Partner <input type="checkbox"/>			
Dependent of Employee <input type="checkbox"/>	or	Dependent of Domestic Partner <input type="checkbox"/>			
Dependent of Employee <input type="checkbox"/>	or	Dependent of Domestic Partner <input type="checkbox"/>			

Affidavits are required for both Domestic Partner coverage and Dependent Child over the age of 19.

SECTION 4: EMPLOYEE APPROVAL

I understand that the above elections are effective for the calendar year 2007 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.)

Signature _____ Date _____

FOR BENEFITS USE ONLY:

Effective Dates: Health _____ Group #: Health _____ Taxability (circle one): DP or Same Sex Spouse

Benefits Specialist _____ Date _____