



## 2008 BENEFITS PROGRAM ENROLLMENT/CHANGE FORM FOR BENEFITS ELIGIBLE EMPLOYEES WORKING 20+ HOURS PER WEEK

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 unless you are enrolling in either of the Flexible Spending Accounts for the new calendar year (this needs to be done each year). **However, if you are waiving coverage, you will be required to complete and return the HIRD Form.** Please return the completed form to the Human Resources Office, MS#15, **by November 16, 2007** for January 1, 2008 effective date, **or within 30 days** from eligibility date.

PERSONAL INFORMATION						
PLEASE CHECK THE APPROPRIATE BOX:			QUALIFYING CHANGE IN FAMILY STATUS:			
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <b>OR</b>			<input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Spouse Coverage			
<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Birth, Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Other _____			
Last Name		First Name	MI	SSN		Employee ID #
Street				City	State	Zip
DOB	Hire Date		Dept #	MS#	Room	Ext.

SECTION 1: HEALTH INSURANCE		
<i>Health Plan Election (Please check one)</i>	<i>Coverage Election (Please check one)</i>	<b>PCP Election for HMO Required</b>
<input type="checkbox"/> HMO New England <i>Enhanced Value</i> <input type="checkbox"/> Access Blue <i>Enhanced Value</i> <input type="checkbox"/> Blue Care Elect - PPO <i>Enhanced Value</i> <input type="checkbox"/> Waive Coverage  <b><i>If waiving coverage you MUST complete and return the Employee Health Insurance Responsibility Form (HIRD Form)</i></b>	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Same Sex Spouse <input type="checkbox"/> Employee + Domestic Partner <input type="checkbox"/> Employee + Family	PCP#
		PCP Name
		PCP#
		PCP Name
		PCP#
		PCP Name
PCP information can be found at <a href="http://www.bcbsma.com">www.bcbsma.com</a>		
As a participant in WHOI benefits, you may enroll a variety of eligible family members for coverage including 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. Your plan covers dependents to age 26, or for two calendar years after the dependent is no longer claimed on the subscriber's or spouse's federal tax return, whichever comes first. For more information, go to <a href="http://www.who.edu/sites/OpenEnrollment">http://www.who.edu/sites/OpenEnrollment</a> .		
* Contributions for the health insurance will automatically default to pre-tax. <b>Please Note:</b> Same Sex Spouse/Domestic Partner coverage may be subject after tax deductions and imputed income.		
* Complete all dependent information (Section 6 of this form) if you are enrolling in coverage other than employee only.		

SECTION 2: DENTAL INSURANCE			
<i>Dental Plan Election (Please check one)</i>		<i>Coverage Election (Please check one)</i>	
<input type="checkbox"/> Delta Dental Premier	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Family
*Contributions for the dental insurance will automatically default to pre-tax. <b>Please Note:</b> Same Sex Spouse/Domestic Partner coverage may be subject after tax deductions and imputed income.			
* Complete all dependent information (Section 6 of this form) if you are enrolling in coverage other than employee only.			

<b>SECTION 3: HEALTH CARE FLEXIBLE SPENDING ACCOUNT</b>	
<i>MUST RE-ENROLL EACH YEAR TO CONTINUE</i>	
<input type="checkbox"/> <b>Waive Coverage</b>	
<input type="checkbox"/> <b>I elect to participate:</b>	<b>Annual Election \$</b> _____ <b>(minimum annual election \$100/maximum \$5,000)</b>
Deductions will be taken evenly over the number of pay periods in the year from your enrollment date. The HFSA is a benefit that needs to be re-elected each calendar year during the Open Enrollment period.)	
<input type="checkbox"/> <b>New Card Request</b>	(The fee for a replacement card is \$5 each and will be deducted from your HFSA.)
*If you are a <b>new enrollee</b> you will automatically receive a <b>FlexExpress Card (debit card)</b> . If you are <b>re-enrolling</b> , your card will be re-programmed for the new annual election unless expired. (Expiration dates are located on the reverse side of card)	
*I understand that the Flex Express Card is to be used only to pay for IRS eligible health and/or dental expenses for me and qualifying persons (see IRS publication 503). The IRS requires that documentation must be kept to support all expenses used for the card, and supply them to Benefits Strategies if requested. Misuses of the card will result in permanent revocation and repayment of ineligible expenses. You cannot use the card in the grace period after the current plan year ends to pay off any expense incurred during the prior plan year. During this period, you must submit your receipts for reimbursement.	

<b>SECTION 4: DEPENDENT CARE REIMBURSEMENT PLAN (DCAP)/DEPENDENT CARE SUBSIDY</b>	
<i>MUST RE-ENROLL EACH YEAR TO CONTINUE</i>	
<b>DEPENDENT CARE REIMBURSEMENT PLAN (DCAP)</b>	
<i>(Please see the DCAP worksheet found on the Open Enrollment web page to assist you in your election.)</i>	
<input type="checkbox"/> <b>Waive Coverage</b>	
<input type="checkbox"/> <b>I elect to participate:</b>	<b>Annual Election \$</b> _____ <b>(minimum annual election \$100/maximum \$5,000)</b>
Deductions will be taken evenly over the number of pay periods in the year from your enrollment date. DCAP is a benefit that needs to be re-elected each calendar year during the Open Enrollment period.)	
<b>DEPENDENT CARE SUBSIDY</b>	
<i>(The Dependent Care Subsidy benefit, paid by WHOI, is in addition to the DCAP.)</i>	
<input type="checkbox"/> <b>Waive Coverage</b>	
<input type="checkbox"/> <b>I elect to participate</b>	

<b>SECTION 5: LIFE INSURANCE/AD&amp;D</b>			
<b>A. Basic Life Election (paid for by WHOI)</b>			
<input type="checkbox"/> <b>1 X Salary</b>			
<input type="checkbox"/> <b>\$50,000</b> (IRS regulations state that the premium for basic life coverage of \$50,000 is taxable to the employee)			
<b>B. Supplemental Life Election (coverage costs are paid fully by the employee)</b>			
<input type="checkbox"/> <b>Employee Coverage</b>	<input type="checkbox"/> <b>Spousal Coverage</b>	<input type="checkbox"/> <b>Child Coverage</b>	<input type="checkbox"/> <b>AD&amp;D</b>
<input type="checkbox"/> <b>Equal to 1 X Salary</b>	Coverage \$ _____	<input type="checkbox"/> <b>\$2,000</b>	<input type="checkbox"/> <b>Individual</b>
<input type="checkbox"/> <b>Equal to 2 X Salary</b>	Election may be made in \$5,000 increments up to \$100,000 maximum	<input type="checkbox"/> <b>\$5,000</b>	<input type="checkbox"/> <b>Family</b>
<input type="checkbox"/> <b>Equal to 3 X Salary</b>	<input type="checkbox"/> <b>Waive Spousal Coverage</b>	<input type="checkbox"/> <b>Waive Child Coverage</b>	Coverage \$ _____
<input type="checkbox"/> <b>Equal to 4 X Salary</b>			<input type="checkbox"/> <b>Waive AD&amp;D</b>
<input type="checkbox"/> <b>Waive Coverage</b>			
<b>Life Insurance Beneficiary Designation</b>			
<b>Primary Beneficiary</b>			
<b>Name</b>	<b>SSN</b>	<b>Relationship</b>	<b>% of Share</b>
<b>Contingent Beneficiary</b>			
<b>Name</b>	<b>SSN</b>	<b>Relationship</b>	<b>% of Share</b>
*If electing coverage for the first time and the supplemental amount exceeds \$250,000, or 3X salary for employee coverage; or the amount exceeds \$30,000 for spousal coverage; or 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**

CHECK ALL THAT APPLY

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

**Affidavits are required for both Domestic Partner coverage and Dependent Children over the age of 19. See <http://www.whoj.edu/sites/OpenEnrollment> for affidavit.**

**SECTION 6: EMPLOYEE APPROVAL**

*I understand that the above elections are effective for the calendar year 2008 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
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**FOR BENEFITS USE ONLY**

<b>Effective Dates</b>	<b>Health</b>		<b>Dental</b>	
	<b>Basic Life</b>		<b>Supplemental Life</b>	<b>Dependent Life</b>
	<b>HFSA</b>		<b>Pay Period Ded \$</b>	<b>Annual Limit \$</b>
	<b>DCAP/DCS</b>		<b>Pay Period Ded \$</b>	<b>Annual Limit \$</b>
<b>Group #</b>	<b>Health</b>		<b>Dental</b>	
<b>Taxability</b>	<input type="checkbox"/> Domestic Partner <input type="checkbox"/> Same Sex Spouse			
<input type="checkbox"/> HIRD Form Received	<input type="checkbox"/> Affidavit of Tax Dependent Status Received		<input type="checkbox"/> Affidavit for Domestic Partner Received	
<b>Affidavit of Tax Dependent Status</b>	<b>Last Tax Year:</b>		<b>Year Eligibility Ends:</b>	
<b>Student Certification Year:</b>				
Benefits Specialist Signature				Date