



2006 BENEFITS PROGRAM ENROLLMENT FORM

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). Please return the completed form to the Human Resources Office, MS#15, by November 14, 2005 for January 1, 2006 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 City State Zip Code
Street _____
DOB _____ Hire Date _____ Dept. # _____ MS# _____ Ext. _____ Status: Single Married

SECTION 2: HEALTH INSURANCE- (Personal Health Assessment to save 12.7%)

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 + Family

PCP Election for HMO Required:
PCP # _____
PCP Name _____

PCP information can be found at www.bcbsma.com

*To complete your PHA please go to www.bluecrossma.com click on Member Self Service (MSS), and go to Register Now. Then create your own user name and password, click on the apple to enter "mybluehealth," on the feature page click the apple again, read how your personal information is kept confidential, click Personal Health Assessment, take your PHA, and save 12.7%!

*Contributions for the health insurance will automatically default to pre-tax.

*Complete all dependent information (section 7 of this form) if you are enrolling in coverage other than employee only.

SECTION 3: DENTAL INSURANCE

Dental Plan Election (please check one)
 Delta Dental Premier Waive Coverage

Coverage Election (please check one)
 Employee Only Employee + Family

*Contributions for the dental insurance will automatically default to pre-tax.

*Complete all dependent information (section 7 of this form) if you are enrolling in coverages other than employee only.

SECTION 4: HEALTH CARE FLEXIBLE SPENDING ACCOUNT – Must Re-Enroll Each Year to Continue

Waive
 I elect to participate: Annual Election \$ _____ (minimum annual election \$100/maximum \$5000)
(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.)

*You will automatically receive a **FlexExpress Card (debit card)**. If your card is lost or stolen, or you wish to purchase cards for your dependents, please contact Benefits Strategies at 1-888-401-FLEX. The fee for a replacement card is \$5 each and will be deducted from your HFSA. Please note that cards will not be reissued each year but will re-programmed for the new annual election.

*I understand that the Flex Express Card is to be used only to pay for IRS eligible health and/or dental expenses. 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.

SECTION 5: DEPENDENT CARE REIMBURSEMENT PLAN (DCAP)/ DEPENDENT CARE SUBSIDY - Must Re-Enroll Each Year to Continue

DEPENDENT CARE REIMBURSEMENT PLAN (DCAP)

(Please see the DCAP worksheet found on the Open Enrollment web page to assist you in your election.)

Waive
 I elect to participate: Annual Election \$ _____ (minimum annual election \$100/maximum \$5000)
(Deductions will be taken evenly over the number of pay periods in the year from your date of enrollment. DCAP is a benefit that needs to be re-elected each calendar year during the Open Enrollment period)

DEPENDENT CARE SUBSIDY

(The Dependent Care Subsidy benefit, paid by WHOI, is in addition to the DCAP.)

Waive
 I elect to participate

SECTION 6: LIFE INSURANCE/AD&D

A. Basic Life Election (paid for by WHOI)

- 1X Salary
- \$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)

(please check accordingly)

- Employee Coverage**
 - Equal to 1X Salary
 - Equal to 2X Salary
 - Equal to 3X Salary
 - Equal to 4X Salary
 - Spousal Coverage**
Election may be made in \$5000 increments not to exceed 50% of employee's life benefit.
Coverage \$ _____
 - Child Coverage**
 - \$2000
 - \$5000
 - AD&D**
 - Individual
 - Family
- Coverage \$ _____
(max of \$500,000 or 10X salary if over \$250,000)

Life Insurance Beneficiary Designation

Primary Beneficiary:

Name	SSN	Relationship	% of Share
_____	_____	_____	_____

Contingent Beneficiary:

Name	SSN	Relationship	% of Share
_____	_____	_____	_____

**If electing coverage for the first time and the amount exceeds \$250,000, or 3X salary; 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 7: DEPENDENT ENROLLMENT INFORMATION

(check all that apply)

Name	SSN	DOB	Sex	Relation	PCP# (HMO)	Health	Dental	DCAP/DCS	Dep Life	AD&D	Student *
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Student refers to dependent children over age 19, who are full-time students.

SECTION 8: EMPLOYEE APPROVAL

I understand that the above elections are effective for the calendar year 2006 and may not be changed during the plan year unless I experience a Qualifying Event as defined by the IRS and I need to 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 _____ Dental _____ Basic Life _____ Supp. Life _____ Dep. Life _____

HFSA _____ DCAP/DCS _____
(per pay deduction) \$ _____ (per pay deduction) \$ _____

Group #: Health _____ Dental _____

Benefits Specialist _____ Date _____