

2008 RETIREE MEDICAL BENEFITS OPEN ENROLLMENT FORM



You are currently enrolled in or, are eligible but have waived participation in, Woods Hole Retiree Medical Benefit Plans. If you are **not making any changes** to your health plan or coverage election from 2007 **or if you have waived coverage** and still do not wish to subscribe to any Woods Hole Retiree Medical Benefit Plans you **do not need to complete this form**. Otherwise please print clearly and complete all necessary sections in full.

PERSONAL INFORMATION				
PLEASE CHECK THE APPROPRIATE BOX: <input type="checkbox"/> New 1 st Time Enrollment <input type="checkbox"/> Changing Plan/Coverage <input type="checkbox"/> Dropping Coverage				
Retiree Name		SSN	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street		City	State	Zip
Telephone		E-mail		
IF YOU AND/OR YOUR SPOUSE ARE OVER 65:				
<i>Retiree (Please check one)</i>		<i>Spouse (Please check one)</i>		
<input type="checkbox"/> Elect Medex II		<input type="checkbox"/> Elect Medex II		
<input type="checkbox"/> Waive Medex II Coverage		<input type="checkbox"/> Waive Medex II Coverage		
IF YOU AND/OR YOUR SPOUSE ARE UNDER 65:				
<i>MEDICAL Health Plan Election (Please check one)</i>		<i>Coverage Election (Please check one)</i>		
<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 Medical Coverage		<input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree + Child <input type="checkbox"/> Retiree + Spouse <input type="checkbox"/> Retiree + Family <input type="checkbox"/> Spouse of over age 65 Retiree <input type="checkbox"/> Spouse + Child(ren) of over age 65 Retiree		
<i>DENTAL Plan Election (Please check one)</i>				
<input type="checkbox"/> Delta Dental Retiree Only <input type="checkbox"/> Delta Dental Family <input type="checkbox"/> Waive Dental Coverage				
DEPENDENT ENROLLMENT INFORMATION (<i>affidavits are required for a dependent child over 19</i>)				
Name	SSN	DOB	Sex	Relation
Spouse				
Dependent				
Dependent				
Dependent				
APPROVAL				
<i>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 Retirement 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 retirement payments all appropriate premiums for my elections or to remit all appropriate premium payments for my elections by the first of each month. I confirm that the information listed above is true and accurate. (Please retain a copy for your records.)</i>				
Signature			Date	