Reviewed by HR:
Initial: _____
Date: _____

FORM MUST BE RETURNED TO HUMAN RESOURCES BY NOVEMBER 20, 2009

2010 BENEFITS PROGRAM OPEN ENROLLMENT 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 medical 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 20, 2009****.*

PERSONAL INFORMATION				
Last Name	First Name	MI	Employee ID#	Work Ext.

SECTION 1: HEALTH INSURANCE

☐ **CHECK BOX IF MAKING "NO CHANGES" TO YOUR MEDICAL COVERAGE FOR 2010**

Health Plan Election (Please check one)	*Coverage Level (Please check one)*	PCP Election for HMO Required	
☐ **Waive Coverage ***	☐ **Employee Only**	PCP#	
☐ **HDHP with HRA (new for 2010)****	☐ **Employee + Child(ren)**	PCP Name	
☐ **HMO New England**	☐ **Employee + Spouse/Ex-Spouse**	PCP#	
☐ **Access Blue**	☐ **Employee + Same Sex Spouse**	PCP Name	
☐ **Blue Care Elect – PPO**	☐ **Employee + Domestic Partner**	PCP#	
Effective 1/1/2010, Blue Care Elect PPO is for out of state employees only.	☐ **Employee + Family**	PCP Name	
****If waiving coverage you MUST complete the separate Employee Health Insurance Responsibility Form (HIRD Form)***		PCP information can be found at www.bcbsma.com	

*** If enrolling in the HDHP, you will automatically be enrolled in a WHOI funded Heath Reimbursement Account and will receive further information on the HRA under separate cover.*

SECTION 2: DENTAL INSURANCE

☐ **CHECK BOX IF MAKING "NO CHANGES" TO YOUR DENTAL COVERAGE FOR 2010**

Dental Plan Election (Please check one)		*Coverage Election (Please check one)*	
☐ **Delta Dental Premier**	☐ **Waive Coverage**	☐ **Employee Only**	☐ **Employee + Family**

IMPORTANT TAX INFORMATION:

As a participant in WHOI's medical and/or dental benefits, you may enroll a variety of eligible family members for coverage including your Spouse/Ex-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 tax years following the loss of their 'section 106' dependent status, whichever occurs first. For more information, go to http://www.whoi.edu/sites/OpenEnrollment.

Contributions for the health and dental insurance will automatically default to pre-tax. ***Please Note:*** *Same Sex Spouse/Domestic Partner/Ex-Spouse, and dependent coverage may be subject to after tax deductions and imputed income.*

IMPORTANT: Complete all dependent information (Section 6 of this form) if you are enrolling in coverage other than employee only.

SECTION 3: HEALTH CARE FLEXIBLE SPENDING ACCOUNT

MUST ENROLL EACH YEAR TO PARTICIPATE

☐ **Waive Coverage** ☐ **I elect to participate:** Annual Election $_____ (minimum annual election $100/maximum $5,000)

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.

IMPORTANT: to enroll you must complete the enclosed Benefit Strategies Enrollment Form (yellow form) and return with this enrollment form.

SECTION 4: DEPENDENT CARE REIMBURSMENT PLAN (DCAP) / DEPENDENT CARE SUBSIDY

MUST ENROLL EACH YEAR TO PARTICIPATE

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

☐ **Waive Coverage** ☐ **I elect to participate:** Annual Election $_____ (minimum annual election $100/maximum $ 5,000)

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.)

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

☐ **Waive Coverage** ☐ **I elect to participate**

If you enroll in the DCAP and/or Subsidy program(s), you will receive an information packet prior to the new year.

SECTION 5: LIFE INSURANCE/AD&D

☐ **CHECK BOX IF MAKING "NO CHANGES" TO YOUR LIFE/AD&D INSURANCE COVERAGE FOR 2010**

A. Basic Life Election *(paid for by WHOI)*

☐ **1 X Salary** (Automatically provided by the employer; or employee can limit coverage to $50,000 to avoid imputed income tax)

☐ **$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)*

☐ **Employee Coverage***	☐ **Spousal Coverage***	☐ **Child Coverage**	☐ **AD&D**
☐ **Equal to 1 X Salary**	Coverage $	☐ **$2,000**	☐ **Individual**
☐ **Equal to 2 X Salary**	Election may be made in $5,000 increments up to $100,000 maximum	☐ **$5,000**	☐ **Family**
☐ **Equal to 3 X Salary**		☐ **Waive Child Coverage**	**Coverage $** _____
☐ **Equal to 4 X Salary**	☐ **Waive Spousal Coverage**		☐ **Waive AD&D**
☐ **Waive Coverage**			

Life Insurance Beneficiary Designation

Primary Beneficiary

Name	SSN	Relationship	% of Share

Contingent Beneficiary

Name	SSN	Relationship	% of Share

**If you are increasing/electing coverage outside your initial eligibility or the amount exceeds $30,000 for spousal coverage, 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

Add	Remove	Change	Name	SSN	DOB	Sex	Relation	PCP# (HMO)	Health	Dental	DCAP/DCS
☐	☐	☐							☐	☐	☐
			☐ **Spouse** ☐ **Domestic Partner** ☐ **Ex-Spouse**								
☐	☐	☐							☐	☐	☐
			☐ **Dependent of Employee** ☐ **Dependent of Domestic Partner**								
☐	☐	☐							☐	☐	☐
			☐ **Dependent of Employee** ☐ **Dependent of Domestic Partner**								
☐	☐	☐							☐	☐	☐
			☐ **Dependent of Employee** ☐ **Dependent of Domestic Partner**								
☐	☐	☐							☐	☐	☐
			☐ **Dependent of Employee** ☐ **Dependent of Domestic Partner**								
☐	☐	☐							☐	☐	☐
			☐ **Dependent of Employee** ☐ **Dependent of Domestic Partner**								

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

SECTION 7: EMPLOYEE APPROVAL

I understand that the above elections are effective for the calendar year 2010 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