HOOD COLLEGE

HEALTH BENEFITS ENROLLMENT FORM

BENEFIT PLAN YEAR: 7/1/19 – 6/30/20

EMPLOYEE INFORMATION: **Complete all information.**

EMPLOYEE LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER
______________________________	______________	_____	___ ___ ___-___ ___-___ ___ ___ ___

EMPLOYEE STREET ADDRESS	CITY	STATE	ZIP
____	__________________	______	_________

EMPLOYEE DAYTIME PHONE NUMBER

(___ ___ ___) ___ ___ ___-___ ___ ___ ___EXT. ___ ___ ___ ___

BENEFIT OPTIONS/PER PAY COST: **Select a level in each category level (e.g., family in each category). No selection indicates no coverage.**

	EMPLOYEE	EMPLOYEE/CHILD	EMPLOYEE/SPOUSE	EMPLOYEE/FAMILY	TOTAL
MEDICAL/RX PLAN – UMR, a United Health Care Co.					
EPO	$58.88	$143.87	$178.57	$210.27	
POS	$207.81	$337.88	$419.32	$470.71	
H S A (High Deductible Health Plan)	$23.08	$95.54	$118.57	$135.01	$________
DENTAL PLAN – MetLife					
High Dental	$23.89	$29.15	$42.27	$56.06	
Standard Dental	$19.87	$22.40	$31.75	$37.89	$________
VISION PLAN – Vision Benefits of America (VBA)	$ 2.71	$ 4.85	$ 4.85	$ 6.62	$________
(A) TOTAL COST OF HEALTH INSURANCE BENEFIT OPTIONS:					$________

FLEXIBLE SPENDING ACCOUNTS (FSAs): **No selection indicates no coverage**

HEALTH CARE FSA ANNUAL ELECTION ($2,700 MAXIMUM) **(B) COST OF YOUR ELECTION:**	$________
LIMITED HEALTH CARE FSA (WITH HSA ELECTION ONLY) FOR NON-MEDICAL EXPENSES ANNUAL ELECTION ($2,700 MAXIMUM) **(C) COST OF YOUR ELECTION:**	$________
DEPENDENT CARE FSA ANNUAL ELECTION ($5,000 MAXIMUM) **(D) COST OF YOUR ELECTION:**	$________
(B OR C + D) TOTAL COST OF FLEXIBLE SPENDING ACCOUNTS (FSAs) BENEFIT OPTIONS:	$________

* If your coverage begins after 7/1/19 and you elect to participate in one or both FSA accounts, your FSA per pay amount must be calculated separately. See an HR Representative.

TO DETERMINE YOUR PER PAY COST FOR THE PLAN YEAR (7/1/19-6/30/20):*

TOTAL COST OF YOUR CHOICES (A + B OR C + D) = TOTAL COST PER PAY:	$________

INFORMATION ON EMPLOYEE, SPOUSE, AND CHILDREN: **Please provide information on all covered family members.**

FULL NAME AND RELATIONSHIP		SOCIAL SECURITY NUMBER	SEX	BIRTHDATE	DISABLED	
	LAST NAME FIRST M.I.				Y/N	DATE DISABILITY BEGAN
SELF						
SPOUSE						
CHILD						
CHILD						
CHILD						
CHILD						
CHILD						

If you are waiving coverage through Hood College, please indicate the waive reason below:

_____Covered by ACA/exchange
_____Covered by other group health plan
_____Covered under other policy
_____Not electing coverage

____ ____________________________
Signature Date

I understand that the above elections will remain in effect until the last day of the Plan Year noted above and, except for any FSA elections (which remain in effect only until the last day of the Plan Year indicated on this Form), will continue in effect indefinitely unless I make an election change permitted under the Plan. I understand that I may change the above elections for a future Plan Year by submitting a new Enrollment Form during a later annual election period. I understand that I may change my elections for coverage during a Plan Year only under limited conditions (as described in my Summary Plan Description). I understand that the cost of a benefit option may change from one Plan Year to the next and I agree that my payroll deductions will automatically change accordingly unless I submit a new Enrollment Form during the appropriate annual election period to change or terminate that coverage. I also understand that, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase or decrease the amount of payroll deductions required to pay for that option. I understand that, except to the extent I am permitted to make an election change under the Plan, the payroll deduction elections I have elected will remain in effect despite any changes in the features offered under the benefit options I have elected. I understand that the Employer may modify my elections as needed to insure that the Plan satisfies the requirements of the Plan and applicable law and that the Employer retains the right to amend or terminate coverage under a benefit option. I understand that the Employer may modify my elections for certain benefit options if required to do so by a court order that requires me to provide health coverage for a dependent. If I am electing any coverage that provides for coverage for an individual as my spouse or dependent on a pre-tax basis, I understand that I am responsible for determining if he or she is eligible to be treated as my spouse or dependent for federal tax purposes. I certify that any person for whom I am electing such coverage meets the applicable requirements for spouse or dependent coverage and I agree to inform the Employer if that changes while this election is in effect. I understand that I will be responsible for reimbursing the Employer for the full cost of any benefits provided to an ineligible dependent.

Employee Signature: **Date:**

FOR HOOD COLLEGE ONLY

HIRE DATE:	EFFECTIVE DATE:	ACCOUNT NUMBER:

Return the completed form to Human Resources.