

NAME _____

ID NUMBER _____

**BRYN MAWR COLLEGE
FLEXIBLE BENEFIT ELECTION FORM
PLAN YEAR NOVEMBER 2011 TO OCTOBER 2012**

EFFECTIVE DATE _____

EMPLOYEE: COMPLETE SECTIONS 1-5. Please see rate sheet for all monthly costs.

SECTION 1: MEDICAL PLAN *(Select one plan and one coverage level.)*

PERSONAL CHOICE PPO	<input type="checkbox"/>	SINGLE	<input type="checkbox"/>
PERSONAL CHOICE PPO HIGH DEDUCTIBLE	<input type="checkbox"/>	SINGLE W/DOMESTIC PARTNER	<input type="checkbox"/>
KEYSTONE POS	<input type="checkbox"/>	PARENT & CHILD	<input type="checkbox"/>
KEYSTONE HMO	<input type="checkbox"/>	PARENT & CHILDREN	<input type="checkbox"/>
		EMPLOYEE & SPOUSE	<input type="checkbox"/>
		FAMILY	<input type="checkbox"/>
WAIVE (SEE SECTION 4)	<input type="checkbox"/>	FAMILY W/DOMESTIC PARTNER	<input type="checkbox"/>

SECTION 2: DENTAL *(Single coverage is an employer-paid benefit. Select a coverage level only if enrolling dependents.)*

SINGLE	<input checked="" type="checkbox"/>	SINGLE W/DOMESTIC PARTNER	<input type="checkbox"/>
		PARENT & CHILD	<input type="checkbox"/>
		PARENT & CHILDREN	<input type="checkbox"/>
		EMPLOYEE & SPOUSE	<input type="checkbox"/>
		FAMILY	<input type="checkbox"/>
		FAMILY W/DOMESTIC PARTNER	<input type="checkbox"/>

SECTION 3: SUPPLEMENTAL LIFE INSURANCE *(Select "Waive" if receiving only the employer-paid basic benefit of \$20,000.)*

COVERAGE AMOUNT

EMPLOYEE birthdate ___/___/___ _____

SPOUSE/DOM. PARTNER birthdate ___/___/___ _____

CHILD(REN) _____

WAIVE NO CHANGES

SECTION 4: MEDICAL INSURANCE WAIVER

IN ORDER TO WAIVE MEDICAL COVERAGE, CERTIFICATION OF GROUP MEDICAL INSURANCE COVERAGE IN FORCE ELSEWHERE FOR THE EMPLOYEE IS REQUIRED. PLEASE COMPLETE THE INSURANCE INFORMATION BELOW. PLEASE PRINT.

Name of Insurance Company _____ Policy /Group # _____

Policyholder/Employer _____ ID # _____

SECTION 5: SUMMARY

- I wish to become insured for the coverage chosen as evidenced by my signature below and agree to the following:
1. I authorize the above selections and, any pre-tax and/or after-tax reductions in pay, as specified on the rate sheet.
 2. I understand that insurance applications are requested for each plan in which I enroll and must be submitted by the due date to ensure enrollment.
 3. I understand that if I waive medical coverage, the subsidy that I receive is fully taxable.
 4. I understand that I cannot change or revoke these elections unless that change or revocation is on account of and consistent with a life event change in status.

SIGNATURE _____ DATE _____

Life Event Change Date _____

Marriage Divorce Birth/Adoption Loss of other group coverage Enrollment in other group coverage Other _____

EMPLOYEE: PLEASE KEEP A COPY FOR YOUR RECORDS