NAME ___________________________________

ID NUMBER _______________

BRYN MAWR COLLEGE
FLEXIBLE BENEFIT ELECTION FORM
PLAN YEAR NOVEMBER 2022 TO OCTOBER 2023

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.)***

Plan		Coverage level	
PERSONAL CHOICE PPO	☐	SINGLE	☐
PERSONAL CHOICE PPO HIGH DEDUCTIBLE	☐	PARENT & CHILD(REN)	☐
KEYSTONE POS	☐	EMPLOYEE & SPOUSE	☐
KEYSTONE HMO	☐	FAMILY	☐

WAIVE (SEE SECTION 4) ☐

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

SINGLE	X	PARENT & CHILD	☐
		PARENT & CHILDREN	☐
		EMPLOYEE & SPOUSE	☐
		FAMILY	☐

SECTION 3: SUPPLEMENTAL LIFE INSURANCE ***(Select "Waive" if receiving only the employer-paid basic benefit of $50,000. Employee and Spouse Elections are in increments of $10,000.)***

		COVERAGE AMOUNT
EMPLOYEE	birthdate ___/___/___	____________________
SPOUSE	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