Rhodes College – Domestic Partner Benefits Enrollment/Change Form 2015-16

Check One: ☐ **New Employee Enrollment** ☐ **Application for New Coverage** ☐ **Change in Coverage/Beneficiary**

EMPLOYEE INFORMATION					
Social Security Number	Last Name	First Name		M.I.	Date of Employment
Street Address	Apt.	Phone		Effective Date	
City	State	Zip	Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married

MEDICAL PLAN – Pittman & Associates, Inc. - Group # G025

Coverage Election (Check One):	Coverage Option:	
☐ I ELECT the group medical coverage offered. ☐ I WAIVE my right to the group medical coverage offered. _____ Type of Coverage/Plan: ☐ Option A ☐ Option B	☐ Employee + Domestic Partner ☐ Employee, Domestic Partner and Family * You will also need to complete an Affirmation of Domestic Partnership Affidavit.	Do you or your dependents have other group medical coverage: ☐ Yes ☐ No If Yes, name of person insured: _____ Insured person's place of employment: _____ Insurance Company & Policy or Group #: _____ Insurance Address: _____

FAMILY MEMBERS TO BE COVERED UNDER MEDICAL PLAN (Failure to include dependent's social security number can cause a delay in coverage.)

	Last Name	First Name	M.I.	Social Security Number	Date of Birth	Gender (M/F)
Self	**SAME AS ABOVE**					
Domestic Partner						
Child						
Child						
Child						
Child						

BASIC LIFE /AD&D **For Office Use Only** **Coverage Amount:**_____

Enter your beneficiary information for BASIC LIFE & AD&D insurance below. Use a separate sheet of paper for additional beneficiary information if needed and make sure to indicate that the information provided is for the BASIC LIFE & AD&D coverage.

Primary

Name:_____ Social Security Number:_____ Date of Birth:_____

Address:_____ Relationship:_____ Share:_____%

Name:_____ Social Security Number:_____ Date of Birth:_____

Address:_____ Relationship:_____ Share:_____%

Secondary

Name:_____ Social Security Number:_____ Date of Birth:_____

Address:_____ Relationship:_____ Share:_____%

Name:_____ Social Security Number:_____ Date of Birth:_____

Address:_____ Relationship:_____ Share:_____%

The Flexible Benefits Plan provides participants a way to pay their Medical & Dental premiums on a pre-tax basis. See the Summary Plan Description for details.

FLEXIBLE BENEFITS PLAN - ELECTION AND SALARY REDUCTION AGREEMENT

I, the undersigned Employee of Rhodes College, hereby make the following election regarding the benefits made available to me under the Rhodes College FLEXIBLE BENEFITS PLAN (the "Plan"). I am further making an election to have my annual, taxable compensation reduced by an amount equal to the total value of the benefits specified below, such annual amount to be deducted in approximately equal sums from my regular paychecks beginning on the date I am eligible to participate and continuing until this election is revoked or modified in accordance with the terms of the Plan.

I further recognize that the reduction in my taxable compensation will remain in effect for each **entire Plan Year period** during which I am a participant, beginning with my participation date and that such election may be changed only during the annual open enrollment period in June of each year or upon the occurrence of a "Change of Status Event", such as termination of employment or change to part-time status by either myself or my domestic partner; marriage; divorce; death of an immediate family member; or birth or adoption of a child; or significant change in premiums or benefits of the health coverage maintained either by me through my Employer, or by my domestic partners through his or her employer; or financial hardship.

I also realize that by taking less taxable pay, my Social Security benefit could be reduced.

ELECTION OF BENEFITS (Check One)

☐ I ELECT to participate in the benefit plan circled below and have my compensation reduced by the premium rate in force during the period of my participation beginning with the rate entered below.

Medical Insurance, Option A

Level of Coverage		2015-16 Employee Cost 26 Pays	22 Pays	20 Pays	Imputed Income 26 Pays	22 Pays	20 Pays
Employee + Domestic Partner	Pre-tax	67.46	79.73	87.70			
	After-Tax	74.42	87.94	96.74	157.99	186.71	205.39
	Total	141.88	167.67	184.44	4,107.74 Annual	4,107.74 Annual	4,107.74 Annual
Employee, Domestic Partner and Family	Pre-tax	115.73	136.79	150.46			
	After-Tax	74.42	87.94	96.74	157.99	186.71	205.39
	Total	190.15	224.73	247.20	4,107.74 Annual	4,107.74 Annual	4,107.74 Annual

Medical Insurance, Option B

Level of Coverage		2015 - 16 Employee Cost 26 Pays	22 Pays	20 Pays	Imputed Income 26 Pays	22 Pays	20 Pays
Employee + Domestic Partner	Pre-tax	36.93	43.64	48.01			
	After-Tax	40.62	48.01	52.80	112.30	132.73	145.99
	Total	77.55	91.65	100.81	2,919.80 Annual	2,919.80 Annual	2,919.80 Annual
Employee, Domestic Partner and Family	Pre-tax	73.85	87.27	96.01			
	After-Tax	40.62	48.01	52.80	112.30	132.73	145.99
	Total	114.47	135.28	148.81	2,919.80 Annual	2,919.80 Annual	2,919.80 Annual

Dental Insurance Split Value		26 Paychecks	22 Paychecks	20 Paychecks
Employee + Domestic Partner	Pre-tax	$9.04	$10.69	$11.75
	After-tax	$9.86	$11.65	$12.82
Employee, Domestic Partner + Family	Pre-tax	$27.07	$32.00	$35.19
	After-tax	$9.86	$11.65	$12.82
After-tax Annualized Imputed Income $256.36				

Dental Insurance PPO		26 Paychecks	22 Paychecks	20 Paychecks
Employee + Domestic Partner	Pre-tax	$14.84	$17.54	$19.29
	After-tax	$17.40	$20.55	$22.61
Employee, Domestic Partner + Family	Pre-tax	$35.83	$42.36	$46.59
	After-tax	$17.40	$20.55	$22.61
After-tax Annualized Imputed Income $452.40				

☐ I waive participation and I acknowledge that I have been given the opportunity to become a participant in my employer's FLEXIBLE BENEFITS PLAN. However, I have chosen not to participate at this time. By waiving participation, I realize that I will not again become eligible to participate until the next plan anniversary date or, if earlier, occurrence of a Change of Status Event, and that my payroll deductions for medical/dental insurance will be on an after-tax basis.

OPTIONAL REIMBURSEMENT ACCOUNT ELECTIONS – Administered by Pittman & Associates, Inc. ** Domestic Partners are not eligible to participate in the Health and/or Dependent Care Personal Spending Accounts **

Health Care Personal Spending Account $_____ Plan Year Amount ($2,500 maximum per plan year)

Child/Dependent Care Personal Spending Account $_____ Plan Year Amount ($5,000 maximum per plan year)

EMPLOYEE STATEMENT AND SIGNATURE

By my signature below I certify that I have received the General Notice regarding COBRA continuation coverage; I have received information about the Rhodes College benefit program including the terms and conditions of beginning and ending participation; I choose to enroll or waive my right to participate as indicated above; I agree to abide by the terms and conditions provided in the plan(s); and I authorize Rhodes College to deduct my share of the premium cost for the plan(s) I have elected. I understand that I have been offered the opportunity to purchase Supplemental Life coverage. If I waive my right to enroll at this time, I understand that in the event I request to purchase such insurance at a later date: (1) I will be required to furnish evidence of insurability on myself, and any dependents, at my own expense; and (2) HCC Life will have the right to refuse my request. Under penalties of perjury I declare that the information which is furnished above, to the best of my knowledge and belief, is correct and complete.

_____ _____

Signature Date