BENEFIT ENROLLMENT & CHANGES FORM – Medical/Dental/Vision

Effective Date: 1/1/16

Employer

Hamilton College ❑ Active ❑ Cobra ❑ Retiree

Employee Information *(please print)*

Last Name	First Name	M.I.	Gender: ❑M / ❑F	Marital Status ❑Married ❑Single

Mailing Address	Social Security Number	Date of Birth

City	State	Zip	Phone	Date Employed

Benefit Election

Coverage	Medical Plan	Dental Plan	Vision Plan
Employee	❑	❑	❑
Employee & Spouse/ Domestic Partner	❑	❑	❑
Employee & Child(ren)	❑	❑	❑
Family	❑	❑	❑
Waive	❑ *Waive Coverage (must complete Medical Plan Waiver section below)*	❑ *Waive Coverage*	❑ *Waive Coverage*

Enroll / Add Dependents

Check Selections and Print entries

Medical	Dental	Vision	Dependent	Name (First and Last)	Social Security #	Date of Birth	Gender	For Dental/Vision- Full Time Student Age 19-23?
❑	❑	❑	❑Spouse ❑ Domestic Partner				❑M ❑F	
❑	❑	❑	Child				❑M ❑F	❑ Y ❑ N
❑	❑	❑	Child				❑M ❑F	❑ Y ❑ N
❑	❑	❑	Child				❑M ❑F	❑ Y ❑ N
❑	❑	❑	Child				❑M ❑F	❑ Y ❑ N
❑	❑	❑	Child				❑M ❑F	❑ Y ❑ N

Medical Plan Other Coverage

At your enrollment date, will you or any enrolled dependent(s) have other medical plan coverage? ❑Yes ❑No

If yes, who does the other plan cover? ❑Self ❑Spouse/Domestic Partner ❑Child(ren)

Other insurance name of policyholder _____ Other insurance carrier name _____

Policy # _____ Effective Date _____ Termination Date _____

Do you or your enrolled dependent(s) currently have Medicare coverage? ❑Yes ❑No If yes, who _____

Reason for Medicare eligibility? ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease

Medicare ID # _____ Part A Effective Date _____ Part B Effective Date _____

Medical Plan Waiver

❑ I am electing NO medical coverage. *Benefits from this election will be added to my taxable income.*

If you waive medical coverage, you must check one box below to indicate your reason

❑ I have medical coverage through my spouse/domestic partner's employer

❑ I have medical coverage through Medicare or Medicaid

❑ I am covered under a stand-alone medical policy (not through a group)

❑ I do not wish to have any medical coverage. I understand I will not receive the College's waiver payment if I do not have other coverage

❑ Other _____

I understand that I must report any change in family status that may impact my medical plan coverage to Human Resources within 30 days of the event.

I further understand that the medical coverage that I am waiving is minimum essential coverage that is considered affordable and meets the minimum value requirements of the Affordable Care Act. I understand that as a result of this coverage offer by the College, I may not be eligible for a premium tax credit if I obtain coverage through an Exchange (Marketplace) plan.

Delete Dependents

Check Selections and Print entries

Medical	Dental	Vision	Dependent	Name (First and Last)
❑	❑	❑	❑Spouse ❑ Domestic Partner	
❑	❑	❑	Child	
❑	❑	❑	Child	
❑	❑	❑	Child	
❑	❑	❑	Child	
❑	❑	❑	Child	

Continued on the back

Authorization	***By signing this form, I agree to the terms and conditions below:*** • *I authorize the College to deduct the required premiums from my wages for the benefits I have elected on a pre-tax basis.* • *I understand that my elections are made for the entire Plan Year and cannot be changed except in limited circumstances allowed under federal law.* • *I understand that if I have a change in status that allows me to add or drop coverage mid-year, my new coverage election will become effective as of the date of the event, but the election will not become effective for payroll purposes until the payroll period following the date that I inform the College of the change in status.* • *I have received a copy of the summary plan description for the benefits I have elected.* • *I understand that my dependent(s) are only allowed to participate in the benefits that I have elected to the extent that they satisfy the eligibility requirements for such benefits and that it is my responsibility to inform the College if there has been a change that affects the eligibility of my dependents.* • *I understand that any misstatements, misrepresentation or omissions made in connection with my enrollment or the enrollment of my dependent(s), in the benefit plans maintained by the College may result in legal, criminal or disciplinary action and/or claim denial or loss of benefits for me and my enrolled dependent(s).* • *The reduction in my wages under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by the College.* • *I understand that In the event that I fail to make any necessary required contributions during an unpaid leave of absence, or as the result of an administrative error, such required contributions will be deducted from my compensation at a later date.* • *Prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete a new election form at that time I will be treated as having elected to make no changes in my benefit elections (other than the flexible spending account benefits offered by the College).* • *The College may reduce or cancel the amount of my salary reduction or otherwise modify this agreement if it is believed advisable to satisfy applicable provisions of the Internal Revenue Code.* • *This agreement is subject to the terms of the Hamilton College Welfare Benefits Plan, as amended from time to time, and revokes any prior election relating to such plan.* • *I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, Excellus BlueCross BlueShield may transmit personal information to third parties with which it contracts, including pharmacy benefit managers, disease management vendors or surveyors.* • *I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.* • *I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.* • *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.* **Employee Printed Name:** _____ **Employee Signature:** _____ **Date:** _____ **Email Address:** _____
IMPORTANT DEADLINE	Employees MUST submit the required enrollment forms and applications by the benefit effective date, as defined by Hamilton College's benefit plan documents; employees who fail to do so waive their right for initial benefit enrollment. The next opportunity to enroll in benefits is during Open Enrollment for benefits effective January 1, 2016, or in the event of an IRS qualifying change in status.

EMPLOYER SECTION	❑ New Hire	❑ Open Enrollment	❑ Status Change
Effective Date: _____		Pay Date: _____	
Pay Period Start: _____		Pay Period End: _____	
E _____	A _____		VSP _____
D _____	PREL _____		
P _____	Reviewed _____		