FY2010 Benefit Election Form
Effective for Plan Year July 1, 2009 – June 30, 2010

Full Name _____ WPI ID # _____

Address _____
STREET CITY, STATE ZIP

☐ ***Check box if address has changed from previous year.***

Phone ( ) _____ ( ) _____
WORK HOME

Date of Birth: _____ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Reason for Submission: ☐ New Hire ☐ Open Enrollment ☐ COBRA ☐ Specific Qualifying Event

BENEFIT SELECTIONS

HEALTH PLAN – BLUE CROSS BLUE SHIELD (PRE-TAX)	**FAMILY**		**INDIVIDUAL**	
	(Monthly)	(Bi-Weekly)	(Monthly)	(Bi-Weekly)
HMO Blue NE $1,000 (Group #4040342)	☐ $ **202.95**	☐ $ **101.48**	☐ $ **76.58**	☐ $ **38.29**
HMO Blue NE Premier Value (Group #4040344)	☐ $ **287.03**	☐ $ **143.52**	☐ $ **108.31**	☐ $ **54.16**
HMO Blue NE Value Plus (Group #40403420	☐ $ **338.22**	☐ $ **169.11**	☐ $ **127.64**	☐ $ **63.82**
BCE PPO Enhanced Value (Group #2322967)	☐ $**448.45**	☐ $ **224.23**	☐ $ **169.22**	☐ $ **84.61**

☐ *I do NOT want group medical insurance. I am waiving my option for FY10* (**complete Waiver of Health Insurance and Health Insurance Responsibility Disclosure**).

EMPLOYEE GROUP WAIVER OF HEALTH INSURANCE

_____
FIRST MIDDLE INITIAL LAST

Massachusetts Health Care Reform requires ALL Massachusetts residents over 18 years of age to have medical insurance. I hereby certify that I have been given an opportunity to participate in one of the group health insurance programs offered through my employer and I do not wish to participate. I understand that I may not be allowed to participate in this benefit until the next annual enrollment unless there is a change in my Family Status, for example, marriage, divorce, birth or adoption of a child, death of a dependent, or the termination of my spouse's/domestic partner's employment.

Insurance Carrier: _____ Subscriber: _____ Member ID#_____

_____
EMPLOYEE SIGNATURE DATE

DENTAL PLAN – BLUE CROSS BLUE SHIELD (PRE-TAX)	**FAMILY**		**INDIVIDUAL**	
	(Monthly)	(Bi-Weekly)	(Monthly)	(Bi-Weekly)
Dental Blue – High (Group #2322915)	☐ $ **98.06**	☐ $ **49.03**	☐ $ **28.75**	☐ $ **14.38**
Dental Blue – Low (Group #2322917)	☐ $ **80.91**	☐ $ **40.46**	☐ $ **22.82**	☐ $ **11.41**

☐ *I do NOT want group dental insurance, I am waiving my option for FY10.*

Please list all dependents covered under your medical **(M)** and/or dental **(D)** policy and place an "x" in the appropriate box.

M	D	First Name	Last Name	Date of Birth	Sex M/F	DC	Primary Care Physician Name and City for Each	Current Doctor?

DC (Dependent Code): 02 SPOUSE 03 CHILD UNDER 19 03 CHILD TAX DEPENDENT 19-25 (MA ONLY) 03 CHILD 19-25 TAX DEP/2 YR EXTN (MA ONLY)
04 FULL-TIME STUDENT 19 AND OVER 05 HANDICAPPED (VERIFICATION REQUIRED) 06 EX-SPOUSE

All group health and dental insurance premium payments will be deducted on a PRE-TAX basis. Contact HR if you would prefer the AFTER TAX method.

FLEXIBLE SPENDING ACCOUNTS (PRE-TAX)

It is necessary to re-elect both your medical and dependent flexible spending amounts for fiscal year 2010 even if you are not making changes. Flexible Spending deductions will be in effect 07/01/09 through 06/30/10.

☐ Medical Care Account: $_____ ANNUAL amount.
Maximum Employee Contribution: $208.33 Bi-Weekly / $416.67 Monthly, $5,000 annually

☐ Dependent Care Account: $_____ ANNUAL amount.
Maximum Employee Contribution: $208.33 Bi-Weekly / $416.67 Monthly, $5,000 annually

☐ *I do NOT wish to participate this year*

BASIC LIFE INSURANCE / ACCIDENTAL DEATH & DISMEMBERMENT – LINCOLN FINANCIAL (PREMIUMS PAID BY WPI)

Please complete this section to name or update your beneficiary designation for your Life Insurance coverage.

Primary Beneficiary Names (Last, First, MI)	**Relationship**	**% of Benefit**

Contingent Beneficiary Names (Last, First, MI)	**Relationship**	**% of Benefit**

SIGNATURE/AUTHORIZATION

While every effort has been made to assure accuracy in the plan definitions on this form, I understand that this is strictly an election form. The contracts that WPI has signed with the insurance carriers will be binding. This form is valid for the period of employment from July 1, 2009 through June 30, 2010. If I terminate my employment prior to June 30, 2010, my election will be valid through the end of the corresponding pay period in which I terminate my employment.

I realize that I may not make a change to my benefit selections during the Plan Year unless it is a change that is necessary and appropriate due to a change in my FAMILY STATUS (e.g., marriage, divorce, birth/adoption of a child, death of a dependent, or the termination of my spouse's/domestic partner's employment).

In the event that my salary for (a) given pay period(s) falls below the total of my benefit election(s) per pay period, reallocation of my salary will be temporarily suspended. At such time that my salary once again exceeds the total of my benefit election(s) per pay period at any time during the period covered by this ELECTION FORM, the terms of this election will remain in full force, and salary reallocation will resume automatically in accordance with the terms of this election. Any amounts that would have been withheld from my salary during the suspension period will be withheld subsequently, in accordance with a schedule determined by the University, during the period ending no later than 30 days following the last day of the Plan Year covered by this election. All deductions for health, dental, and flexible spending accounts are taken on a pre-tax basis unless you notify the Office of Human Resources in writing.

I further understand that any positive balance in my flexible spending accounts (medical and/or dependent care) at the end of the Plan Year will be forfeited to Worcester Polytechnic Institute in compliance with the Internal Revenue Code's Section 125 Regulations.

_____ _____
EMPLOYEE SIGNATURE DATE EMPLOYER SIGNATURE DATE