WHITMAN COLLEGE
BENEFIT ENROLLMENT FORM

Name:_____
Last First M.I.

Effective Date:_____ FTE: ☐100% ☐Other____

Employee ID Number_____

Reason: ☐New Enrollment ☐Change in Family Status ☐ Open Enrollment

Note: Check a box for each benefit below – See Benefit Summary for Eligibility

	No Change	Change*/Add	Coverage Category (check & circle all that apply)		
Basic Life & AD&D	☐	☐	Employee	Dependent	
Supplemental Life	☐	☐	Employee	Spouse	Child
Supplemental AD&D	☐	☐	Employee	Spouse	Child

Changes may be requested from Lincoln with submission of application and evidence of insurability forms at any time. Requests for changes as Late Entrants are subject to approval from Lincoln before becoming effective. Contact Human Resources for assistance.

Medical Coverage

Coverage Category (check & circle one)

☐ **No Change** ☐ **Change*/Add**

Option A: PPO Employee | Employee & Spouse | Employee & Children | Family (Employee, Spouse & Children) | Employee & DP **

Option B: Cash-in-lieu of medical benefits (Available only to employees hired before 1/1/2012)

Option C: Decline Medical Coverage (Complete a Waiver of Coverage Form)

Dental Coverage

Coverage Category (check & circle one)

☐ **No Change** ☐ **Change*/Add**

Option A: Employee | Employee & Spouse | Employee & Children | Family (Employee, Spouse & Children) | Employee & DP **

Option B: Decline Dental Coverage (Complete a Waiver of Coverage Form)

*NOTE: Change requires PREMERA or Lincoln Enrollment Form in addition to Whitman Changes to Elections Form

** NOTE: Domestic partner premiums cannot be processed on a pre-tax basis. A statement of domestic partnership must be completed.

OVER FOR REQUIRED SIGNATURE

Whitman College

Salary Reduction Agreement:

I authorize Whitman College to make any payroll deductions as required by my benefit choices on page one of this form. If I am selecting Option C (Decline Medical Coverage), I realize I am eligible for Whitman Healthcare Coverage but I elect not to participate in the Whitman College Plan. If I am an eligible part-time employee, I understand I will pay a pro-rata share of my employee medical coverage based on my appointed FTE.

This agreement shall be legally binding and irrevocable for both the employee and Whitman College while employment continues except as specifically noted. This agreement may be revoked by the execution of a new agreement during the annual open enrollment period each December. This agreement may also be revoked when there is a change in family status consistent with the requested change in coverage. The change in coverage must be made within 60 days of the change in family status event, which includes: 1) marriage, divorce, starting or terminating domestic partner status; 2) birth, adoption, or attaining a limiting age (26) for a child;
3) death of a spouse, domestic partner, or child; 4) substantial change in employment status of employee, spouse or domestic partner which results in the loss or availability of coverage (full- time to part-time, benefit eligible to non-benefit eligible, or change of employer); 5) substantial change (25%) in health care benefits of employee, spouse or domestic partner (increase in deductible, copayments, increase/decrease in premium cost, change from POS/PPO/HMO, state law change).

Premiums and benefits for employees and dependents may vary from one calendar year to another. Employees and/or dependents applying for medical coverage after the initial 31-day enrollment period (late applicants) may do so only if there is a change in family status consistent with the enrollment request or during the annual open enrollment period in December.

Date:_____ Employee Signature: _____

Print Name:_____