Colby College Benefits Enrollment Form

Plan Year: January 1, 2019 - December 31, 2019

Name: ______________________ Social Security Number: ______________________

Street: ______________________ Date of Birth: ______________________

City, St, Zip: ______________________ Phone Number: ______________________

Marital Status: ☐ Single ☐ Married Payroll Status (check one): ☐ Bi-weekly ☐ Monthly

Sex: ☐ Male ☐ Female **EFFECTIVE DATE:** ______________________

☐ **INITIAL ENROLLMENT** ☐ **STATUS CHANGE – REASON:** ______________________

*Reasons: marriage, divorce, birth/adoption, death, and gain/loss of coverage – supporting documentation required

MEDICAL INSURANCE – Amounts in ( ) are bi-weekly amounts

Plan Name	Coverage Level	Salary <$37,500	Salary $37,500 - $76,499	Salary $76,500 & Over
Open Access In-Network (OAPIN)	Employee Only	$24.00 ($12.00)	$46.00 ($23.00)	$70.00 ($35.00)
	Employee + 1	$187.00 ($93.50)	$264.00 ($132.00)	$348.00 ($174.00)
	Employee + Family	$248.00 ($124.00)	$356.00 ($178.00)	$449.00 ($224.50)
Open Access Plus (OAP)	Employee Only	$20.00 ($10.00)	$40.00 ($20.00)	$60.00 ($30.00)
	Employee + 1	$170.00 ($85.00)	$239.00 ($119.50)	$298.00 ($149.00)
	Employee + Family	$230.00 ($115.00)	$331.00 ($165.50)	$399.00 ($199.50)
Health Savings Account (HSA)*	Employee Only	$14.00 ($7.00)	$23.00 ($11.50)	$36.00 ($18.00)
	Employee + 1	$120.00 ($60.00)	$175.00 ($87.50)	$250.00 ($125.00)
	Employee + Family	$180,00 ($90.00)	$275.00 ($137.50)	$350.00 ($175.00)

*For the HSA plan, Colby contributes $84.00 ($42.00) each month for single and $167.00 ($83.50) each month for family

Please elect the plan and level of coverage

Employee Only	Employee + 1	Employee + Family	
☐ OAPIN ☐ OAP ☐ HSA	☐ OAPIN ☐ OAP ☐ HSA	☐ OAPIN ☐ OAP ☐ HSA	☐ Decline Coverage

Please list spouse and/or dependents needing medical coverage

	FULL NAME	SEX (M/F)	DOB	SSN
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				
Dependent				

Other Medical Coverage

Do you, your spouse, or your dependents have other insurance through a group plan, HMO, or Medicare? ☐ Yes ☐ No

Name of Person(s) Covered	Effective Date	Part A, Part B, Medicaid or Name of Other Insurance

DENTAL INSURANCE – Amounts in ( ) are bi-weekly amounts

- ☐ Employee Only – $8.00 ($4.00)
- ☐ Employee + 1 – $29.00 ($14.50)
- ☐ Employee + Family – $52.00 ($26.00)
- ☐ Decline Coverage

Please list spouse and/or dependents needing dental coverage

	FULL NAME	SEX (M/F)	DOB	SSN
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

VISION INSURANCE – Amounts in ( ) are bi-weekly amounts

- ☐ Employee Only – $8.56 ($4.28)
- ☐ Employee + Family – $18.40 ($9.20)
- ☐ Decline Coverage

FLEXIBLE SPENDING ACCOUNTS

NOTE: HSA participants may not enroll in the Medical Reimbursement Account but may enroll in the Limited Purpose Flexible Spending (LPFS). LPFS is limited to dental and vision expenses only.

☐ **MEDICAL REIMBURSEMENT ACCOUNT** – $2,650 Limit

I elect an annual contribution amount of $ ___________________

☐ **LIMITED PURPOSE FLEXIBLE SPENDING** – $2,650 Limit

I elect an annual contribution amount of $ ___________________

☐ **DEPENDENT CARE ACCOUNT** – $5,000 limit for a single parent or if you are married and file a joint tax return. $2,500 limit if you are married and you and your spouse file separate tax returns.

I elect an annual contribution amount of $___________________. If this amount exceeds $2,500, I certify that:

- ☐ I will file a joint federal income tax return with my spouse for the year
- ☐ I am not married

☐ **I DO NOT WISH TO PARTICIPATE IN ANY REIMBURSEMENT ACCOUNTS**

EMPLOYEE LIFE INSURANCE

BASIC LIFE INSURANCE AMOUNTS BY AGE – Paid for by the College

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60+
Amount	$50,000	$45,000	$40,000	$35,000	$30,000	$25,000	$20,000	$15,000

OPTIONAL LIFE INSURANCE – You cannot elect more than 5x your annual earnings.

Applicable to initial offer only: Guaranteed Issue (GI) amount of the lesser of $200,000 or 3x your annual earnings. If electing more than the GI amount, you must complete an Evidence of Insurability (EOI) form and submit it to The Hartford for approval.

Monthly Rate by Age Group

Level of Coverage	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
☐ $50,000	$3.00	$4.00	$4.50	$7.00	$11.00	$19.00	$26.00	$36.00	$63.50	$112.50	$191.50
☐ $100,000	$6.00	$8.00	$9.00	$14.00	$22.00	$38.00	$52.00	$72.00	$127.00	$225.00	$383.00
☐ $150,000	$9.00	$12.00	$13.50	$21.00	$33.00	$57.00	$78.00	$108.00	$190.50	$337.50	$574.50
☐ $200,000	$12.00	$16.00	$18.00	$28.00	$44.00	$76.00	$104.00	$144.00	$254.00	$450.00	$766.00
☐ $250,000	$15.00	$20.00	$22.50	$35.00	$55.00	$95.00	$130.00	$180.00	$317.50	$562.50	$957.50
☐ $300,000	$18.00	$24.00	$27.00	$42.00	$66.00	$114.00	$156.00	$216.00	$381.00	$675.00	$1,149.00
☐ $350,000	$21.00	$28.00	$31.50	$49.00	$77.00	$133.00	$182.00	$252.00	$444.50	$787.50	$1,340.50
☐ $400,000	$24.00	$32.00	$36.00	$56.00	$88.00	$152.00	$208.00	$288.00	$508.00	$900.00	$1,532.00
☐ $450,000	$27.00	$36.00	$40.50	$63.00	$99.00	$171.00	$234.00	$324.00	$571.50	$1,012.50	$1,723.50
☐ $500,000	$30.00	$40.00	$45.00	$70.00	$110.00	$190.00	$260.00	$360.00	$635.00	$1,125.00	$1,915.00

BENEFICIARY DESIGNATION – Please designate beneficiaries for basic/optional life insurance. Since Colby provides basic life insurance coverage, a beneficiary must be on file.

NOTE: If opting for spouse and/or dependent life insurance, employee is the beneficiary.

PRIMARY

FULL NAME	SSN	DOB	STATE OF RESIDENCE	RELATIONSHIP	%

CONTINGENT

FULL NAME	SSN	DOB	STATE OF RESIDENCE	RELATIONSHIP	%

SPOUSE & DEPENDENT LIFE INSURANCE

SPOUSAL LIFE INSURANCE – Rates are monthly
You may elect coverage in increments of $10,000 up to a maximum of $50,000.

Use the rate chart below to determine the cost for each $10,000 of spousal coverage. The amount elected may never exceed 100% of the combined total of basic and optional life insurance for the employee.

Level of Coverage	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
☐ $10,000	$.60	$0.80	$.90	$1.40	$2.20	$3.80	$6.10	$7.90	$12.70	$22.50	$38.30
☐ $20,000	$1.20	$1.60	$1.80	$2.80	$4.40	$7.60	$12.20	$15.80	$25.40	$45.00	$76.60
☐ $30,000	$1.80	$2.40	$2.70	$4.20	$6.60	$11.40	$18.30	$23.70	$38.10	$67.50	$114.90
☐ $40,000	$2.40	$3.20	$3.60	$5.60	$8.80	$15.20	$24.40	$31.60	$50.80	$90.00	$153.20
☐ $50,000	$3.00	$4.00	$4.50	$7.00	$11.00	$19.00	$30.50	$39.50	$63.50	$112.50	$191.50

DEPENDENT LIFE INSURANCE – Rates are monthly
Live birth but under age 6 months – you may not elect more than $2,000

Please check one of the boxes below indicating the level of coverage and the box that corresponds to the number of dependents you wish to cover.

☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $8,000 ☐ $10,000

# of Dependents	$2,000	$4,000	$6,000	$8,000	$10,000
☐ 1	$0.28	$0.56	$0.84	$1.12	$1.40
☐ 2	$0.56	$1.12	$1.68	$2.24	$2.80
☐ 3	$0.84	$1.68	$2.52	$3.36	$4.20
☐ 4	$1.12	$2.24	$3.36	$4.48	$5.60
☐ 5	$1.40	$2.80	$4.20	$5.60	$7.00
☐ 6	$1.68	$3.36	$5.04	$6.72	$8.40
☐ 7	$1.96	$3.92	$5.88	$7.84	$9.80
☐ 8	$2.24	$4.48	$6.72	$8.96	$11.20
☐ 9	$2.52	$5.04	$7.56	$10.08	$12.60
☐ 10	$2.80	$5.60	$8.40	$11.20	$14.00

Please list spouse and/or dependents for life insurance coverage

	FULL NAME	SEX (M/F)	DOB	SSN
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				
Dependent				

Colby College and I hereby agree that my regular compensation will be reduced as set forth in my elections, in approximately equal installments for each pay period during the Plan Year. In addition, I have read and I understand the following conditions regarding coverage:

- I cannot change or revoke my election to receive health or dependent care coverage at any time during the Plan Year unless that change or revocation is on account of and consistent with a change in status. Examples include marriage or divorce, death of a spouse or dependent, birth or adoption of a child, commencement or termination of my spouse's employment, my or my spouse's unpaid leave of absence or change from full-time to part-time employment (or vice versa), and such other events as the Plan Administrator determines. I cannot change or revoke the medical reimbursement election and related compensation reduction agreement at any time during the Plan Year.
- If I choose not to receive my medical benefit coverage through Colby College, I have attached to this form, documentation indicating that I am receiving medical coverage through a sponsor other than Colby College. I understand that, in view of this waiver, I will receive an additional cash benefit of $720 for the Plan Year (proportionately reduced, if for less than the full Plan Year). I also understand that I cannot change or revoke this election as of any date prior to the next Plan Year, unless that change or revocation is on account of and consistent with a change in status, as described above.
- Any change or revocation of dependent care assistance or any other coverage during the Plan Year shall have no effect on the election of medical reimbursements and the related compensation reduction agreement set forth in this agreement.
- Prior to January 1 of each year, I will be offered the opportunity to change my benefit coverage's for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having electing to continue the same health coverage as in effect for the current Plan Year, and will be treated as having elected no coverage under the Dependent Care and Medical Reimbursement Plans.
- The Plan Administrator may reduce or cancel my coverage amount or compensation reduction, limit my reimbursements, or otherwise modify this agreement in the event the Administrator believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.

With respect to my election to receive coverage under the Flexible Spending Account, Dependent Care, or Medical Reimbursement Plan, I also understand that:

- The coverage amount elected under the Dependent Care Plan and/or the Medical Reimbursement Plan will be credited to a dependent care assistance account and/or medical reimbursement account for the year on the books of the College. I will be reimbursed, up to the balance of the annual election in the account, for my qualifying expenses during the year.
- In the case of the dependent care account, reimbursement will be made only for "qualifying dependent care expenses" and in the case of medical reimbursement account, reimbursement will be available only for the "qualifying medical care expenses" described in the Group Dynamic Pamphlet.
- I agree to submit to the College substantiation for the above expenses, and further agree to notify the College if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the College on demand for any liability it may incur for failure to withhold federal and state income tax or social security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax owed by me.
- The dependent care election and related compensation reduction agreement shall terminate automatically if the Dependent Care Assistance Plan is terminated or discontinued, or if I cease to receive compensation from the College, which, before reduction hereunder, is at least equal to twice the amount of that reduction.
- Any account balances remaining 90 days after the end of the Plan Year shall be forfeited.
- This agreement is subject to the terms of the Colby College Cafeteria Plan, the Colby College Dependent Care Assistance Plan, and the Colby College Medical Reimbursement Plan as from time to time in effect, shall be governed by and construed in accordance with the laws of the State of Maine, shall take effect as a sealed instrument under the law of the State of Maine, and revokes any prior election and compensation reduction agreement relating to either the Dependent Care Assistance Plan or the Medical Reimbursement Plan.

EMPLOYEE SIGNATURE	DATE	ACCEPTED & AGREED TO BY COLBY COLLEGE	DATE