EMERSON COLLEGE Benefits Enrollment Form

INSTRUCTIONS: Please complete section 1 and any other applicable sections. Sign and date section 7. Make a copy and retain for your records. Forward completed form to Human Resources.

Type of Enrollment: ☐ New Hire ☐ Open Enrollment ☐ Termination ☐ Change (specify): ___________________________

Section 1: Employee Information

Name:____ **SSN:**________--________--________ **Date of Birth:**________________

Street:____ **City:**________________________ **State:**______ **Zip:** ___________

Status: ☐ Single ☐ Married ☐ Same-sex Domestic Partner (If selecting this status, please contact HR for additional forms.)

Sex: ☐ Female ☐ Male

Pay cycle: ☐ Weekly ☐ Semi-Monthly ☐ Staff ☐ Full-time Faculty ☐ Part-time Faculty

Section 2: Health Insurance (pre-tax)

Health Plan Election (please check ONE)
☐ Harvard Pilgrim HMO
☐ Harvard Pilgrim POS
☐ Waive coverage ⊥

Coverage Election (please check ONE)
☐ Individual
☐ Family*

Primary Care Physician REQUIRED
PCP #_____________________
PCP Name_____________________
Location_____________________
Are you a current patient? ☐ Yes ☐ No
PCP information can be found at www.hphc.org

**Complete dependent information in Section 6*

⊥ Complete Employee Health Insurance Responsibility Disclosure Form

HR Use Only	☐ Entered into HRIS ☐ Submitted to Provider	Effective Date:	Group Number:

Section 3: Dental Insurance (pre-tax)

Dental Plan Election (please check ONE)
☐ Delta Dental Premier USA ☐ Waive Coverage

Coverage Election (please check ONE)
☐ Individual ☐ Family*

Are you or other family members currently covered by another plan? ☐ Yes ☐ No
If YES, please indicate name of covered individual________________________________.
Other Dental Insurance Co: Employer Name: Policy Holder ID #: Effective Date:

____

**Complete dependent information in Section 6*

HR Use Only	☐ Entered into HRIS ☐ Submitted to Provider	Effective Date:	Group Number:

Section 4: Medical Flexible Spending Account (pre-tax)

☐ Waive Annual Election $________________ (minimum $120, maximum $3,000)
☐ I elect to participate $_____________ per ☐ Week ☐ Semi-Month

Based on your enrollment date, equal deductions will be taken over the number of pay periods remaining in the calendar year. Flexible Spending Account benefits need to be re-elected each calendar year. Per IRS regulations, any unused amounts will be forfeited.

HR Use Only	☐ Entered into HRIS ☐ Submitted to Provider	Effective Date:	Group Number:

Section 5: Dependent Care Flexible Spending Account (pre-tax)

☐ Waive Annual Election $_________________ *(minimum $120, maximum $5000)*
☐ I elect to participate $_____________ per ☐ Week ☐ Semi-Month

Based on your enrollment date, equal deductions will be taken over the number of pay periods remaining in the calendar year. Flexible Spending Account benefits need to be re-elected each calendar year. Per IRS regulations, any unused amounts will be forfeited.

HR Use Only	☐ Entered into HRIS	Effective Date:	Group Number:

Section 6: Dependent Enrollment Information (Spouse, Child or Domestic Partner)

Name	SSN	DOB	Sex	Relation	PCP Name	Health	Dental
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

Affidavit required for dependent children over age 19

Section 7: Employee Approval

I understand that my health, dental, and flexible spending accounts may not be changed during the plan year unless I experience a qualifying event as defined by the IRS. I must supply the Office of Human Resources with the necessary documentation within 30 days of said event. By not enrolling in these benefits at this time, I realize that I will not be able to enroll until the next open enrollment unless I experience a qualifying event.

I agree to abide by the regulations and terms of the plans I have enrolled in according to the summary plan descriptions for each plan. I authorize Emerson College to deduct from my paycheck all appropriate premiums, pre or post-tax, for my elections. I certify that the information listed above is true and accurate.

Employee Signature____ **Date**_________________

For HR Use Only:

Benefit Plan Administrator____ **Date**____________________

☐ **COBRA Initial Notice Sent**_________ ☐ **LTD**__________ ☐ **Life**_________ ☐ **Retirement**_________