For Internal Use
Banner Entry: ______________
Business Solver Entry: _______

BENEFITS ENROLLMENT/CHANGE FORM
(Due to Human Resources no later than 30 days from event date)

April 1, 2014 – March 31, 2015

Name:	**R Number#:**
Payroll: ❑ Monthly ❑ Bi-Weekly	**Pay Months:** ❑ 9 Months ❑ 10 Months ❑ 11 Months ❑ 12 Months
Effective Date:	

Type of Event (Check one):
❑ New Hire
❑ Birth/Adoption ❑ Marriage/Partnership ❑ Divorce
❑ Spouse/DP gains coverage elsewhere ❑ Spouse/DP loses coverage elsewhere
❑ Child gains coverage elsewhere ❑ Child loses coverage elsewhere
❑ Other ___________________________

Premium deductions will be taken on a Before-Tax basis, with the exception of Voluntary Life Insurance and Long-Term Care, which are after-tax benefits. If you are interested in electing all benefits on an after-tax basis, please contact Human Resources.

MEDICAL ❑ No Change

Proof of Prior Coverage: ❑ Attached ❑ To Follow

Plan:	Coverage Category:
❑ Preferred PPO Blue Options	❑ Employee Only
❑ PPO 70 Blue Options	❑ Employee + Spouse/DP
❑ Waive	❑ Employee + Child(ren)
❑ Waive (covered elsewhere)	❑ Employee + Family

DENTAL ❑ No Change

Plan:	Coverage Category:
❑ Humana DHMO	❑ Employee Only
❑ Humana PPO Preventive Plus Plan	❑ Employee + 1
❑ Humana PPO High Plan	❑ Employee + Family
❑ Waive	

VISION ❑ No Change

Plan:	Coverage Category:
❑ Standard Plan	❑ Employee Only
❑ Enhanced Plan	❑ Employee + Family
❑ Waive	

VOLUNTARY LIFE ❑ No Change

Plan:	EOI Required (check if applicable):
❑ Employee Life $______________ ❑ Waive	❑ Employee Life (over $150,000)
❑ Spouse/DP Life $______________ ❑ Waive	❑ Spouse/DP Life (over $50,000)
❑ Child Life $________________ ❑ Waive	

MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA) ❑ No Change

Please note that money deposited into this account must be used by 6/15/2015 and claimed by 6/30/2015 (must re-elect each year).
❑ Health Care FSA Annual Election $______________
❑ Waive

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) ❑ No Change

Please note that money deposited into this account must be used by 6/15/2015 and claimed by 6/30/2015 (must re-elect each year).
❑ Dependent Care FSA Annual Election $______________
❑ Waive

Covered Dependent Information – List who should be covered:

Name:	**DOB:**	**Gender:** ❑ Male ❑ Female	**Coverage:** ❑ **Medical** ❑ **Dental** ❑ **Vision**
Relationship: ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Step-Child ❑ Other: __________________			
SSN (required for medical coverage)**:**			

Name:	**DOB:**	**Gender:** ❑ Male ❑ Female	**Coverage:** ❑ **Medical** ❑ **Dental** ❑ **Vision**
Relationship: ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Step-Child ❑ Other: __________________			
SSN (required for medical coverage)**:**			

Name:	**DOB:**	**Gender:** ❑ Male ❑ Female	**Coverage:** ❑ **Medical** ❑ **Dental** ❑ **Vision**
Relationship: ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Step-Child ❑ Other: __________________			
SSN (required for medical coverage)**:**			

Name:	**DOB:**	**Gender:** ❑ Male ❑ Female	**Coverage:** ❑ **Medical** ❑ **Dental** ❑ **Vision**
Relationship: ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Step-Child ❑ Other: __________________			
SSN (required for medical coverage)**:**			

Authorization

I authorize Rollins College to deduct from my pay any premiums required for my elections. I understand that the elections paid for on a **before-tax** basis (with the exception of Voluntary Life and Long-Term Care which are after-tax benefits) are effective through March 31, 2015 and may not be changed or dropped during the benefit plan year unless I have a qualified status change. If I have a status change, I have **thirty days** to make changes to my benefits. I understand that any amount not used by the end of the plan year under the Flexible Spending Account will be forfeited and that a new account must be elected each year during open enrollment.

Signature____ **Date**______________________