



ANNUAL BENEFIT ELECTION FORM ~ NOVEMBER 1, 2011 - OCTOBER 31, 2012
(Rates Effective January 1, 2012)

Section I: Personal Information

Name _____ **PLEASE PRINT CLEARLY!**
 Home Address _____ Home Phone #: _____ **Effective Date:** 11/1/2011
 _____ Home Email _____ **Date of Hire:** _____

List Dependent(s) ~ Also, if using the Clinical Medical/Dental Panels, indicate physician/dentist.

Name	Relationship	Gender	Date of Birth	SSN	Panel Physician	Panel Dentist
	SELF					

Section II: Health Savings Account (HSA) - For High Deductible Health Plan (HDHP) Participants Only

Will you will be opening an HSA, or continuing to contribute to an existing HSA, along with your sign-up for the HDHP?
 YES _____ NO _____ If YES, what is the amount/month you wish to contribute via payroll deduction: _____

Section III: Benefit Election - Medical Coverage

Circle desired level of coverage and enter corresponding amount on Line A, B, or C.

TIER 1 - FTE Salary UNDER \$41,200

	Keystone POS* Base Plan	Keystone HMO* Plan Option	PC 20/30/70 PPO Buy-Up Plan	PC HDHP Option	
Individual	\$ 307.20	\$ 283.50	\$ 416.26	\$ 197.75	A. _____
Employee & Child/ren	\$ 566.54	\$ 524.56	\$ 962.87	\$ 523.01	
Couple	\$ 743.59	\$ 689.14	\$ 1,151.96	\$ 566.21	
Family	\$ 964.83	\$ 894.81	\$ 1,118.63	\$ 515.66	

TIER 1

Enter Monthly Cost

***Primary Care Physician must be selected**

TIER 2 - FTE Salary BETWEEN \$41,201 - \$82,399

	Keystone POS* Base Plan	Keystone HMO* Plan Option	PC 20/30/70 PPO Buy-Up Plan	PC HDHP Option	
Individual	\$ 307.20	\$ 283.50	\$ 416.26	\$ 197.75	B. _____
Employee & Child/ren	\$ 566.54	\$ 524.56	\$ 962.87	\$ 523.01	
Couple	\$ 743.59	\$ 689.14	\$ 1,151.96	\$ 566.21	
Family	\$ 964.83	\$ 894.81	\$ 1,118.63	\$ 515.66	

TIER 2

Enter Monthly Cost

***Primary Care Physician must be selected**

TIER 3 - FTE Salary \$82,400 & OVER

	Keystone POS* Base Plan	Keystone HMO* Plan Option	PC 20/30/70 PPO Buy-Up Plan	PC HDHP Option	
Individual	\$ 307.20	\$ 283.50	\$ 416.26	\$ 197.75	C. _____
Employee & Child/ren	\$ 566.54	\$ 524.56	\$ 962.87	\$ 523.01	
Couple	\$ 743.59	\$ 689.14	\$ 1,151.96	\$ 566.21	
Family	\$ 964.83	\$ 894.81	\$ 1,118.63	\$ 515.66	

TIER 3

Enter Monthly Cost

Section IV: Benefit Election - Waiver of Medical Coverage (if applicable)

Verification of Other Coverage is required. Enter \$62.50 on Line D. _____

Section V: Benefit Election - Vision Coverage (Note: Vision is included with the Keystone Plans)

Enter monthly amount on Line E.

Individual	Two-Person	Family
\$2.93	\$7.63	\$7.63

Section VI: Flexible Spending Accounts: Enter Monthly Amt. on Line F and/or Line G

Medical Expenses	Maximum of \$416.67/month or \$5000/year	F. _____
Dependent Day Care Expenses	Maximum of \$416.66/month or \$5000/year	G. _____

I have read and understand the explanation I have received concerning the Haverford College benefits election. I hereby apply for the options listed above. If necessary, I authorize Haverford College to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force for 11/1/2011-10/31/2012.

Signature _____ Date _____ (PT)