



# FALL 2009 BENEFIT ELECTION FORM

November 1, 2009 - OCTOBER 31, 2010

**Section I: Personal Information**

Name \_\_\_\_\_ Effective Date 11/1/2009  
 SSN \_\_\_\_\_ Date of Hire \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Gender (Circle) Male Female (Print Clearly)  
 Home Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_

**List Dependents to Be Covered**

Name	Relationship	Gender	DOB	SSN

**Section II: Benefit Election - Medical Coverage**  
 Circle desired level of coverage and enter corresponding amount on Line A or B

FTE Salary **UNDER** \$40,000

	Keystone POS* Base Plan	Keystone HMO* Other Option	PC 20/30/70 Buy-Up	PC 20/20/80 Buy-Up	
Single	\$ 272.74	\$ 251.90	\$ 396.10	\$ 453.17	Salary <b>Under</b> \$40,000 Enter Monthly Cost A. _____
Employee & Child	\$ 502.99	\$ 466.07	\$ 840.96	\$ 952.88	
Employee & Children	\$ 502.99	\$ 466.07	\$ 962.19	\$ 1,085.26	
Couple	\$ 660.17	\$ 612.29	\$ 1,088.55	\$ 1,232.76	
Family	\$ 856.60	\$ 795.03	\$ 1,064.77	\$ 1,219.98	

**\*Primary Care Physician must be selected**

FTE Salary **BETWEEN** \$40,000 - \$79,999

	Keystone POS* Base Plan	Keystone HMO* Other Option	PC 20/30/70 Buy-Up	PC 20/20/80 Buy-Up	
Single	\$ 285.73	\$ 264.89	\$ 409.09	\$ 466.16	Salary <b>Between</b> \$40,000 - \$79,999 Enter Monthly Cost B. _____
Employee & Child	\$ 525.99	\$ 489.07	\$ 863.96	\$ 975.88	
Employee & Children	\$ 525.99	\$ 489.07	\$ 985.19	\$ 1,108.26	
Couple	\$ 690.00	\$ 642.12	\$ 1,118.38	\$ 1,262.59	
Family	\$ 894.97	\$ 833.40	\$ 1,103.14	\$ 1,258.35	

**\*Primary Care Physician must be selected**

FTE Salary **OVER** \$80,000

	Keystone POS* Base Plan	Keystone HMO* Other Option	PC 20/30/70 Buy-Up	PC 20/20/80 Buy-Up	
Single	\$ 298.72	\$ 277.88	\$ 422.08	\$ 479.15	Salary <b>Over</b> \$80,000 Enter Monthly Cost C. _____
Employee & Child	\$ 559.00	\$ 522.08	\$ 896.97	\$ 1,008.89	
Employee & Children	\$ 559.00	\$ 522.08	\$ 1,018.20	\$ 1,141.27	
Couple	\$ 736.68	\$ 688.80	\$ 1,165.06	\$ 1,309.27	
Family	\$ 958.73	\$ 897.16	\$ 1,166.90	\$ 1,322.11	

**\*Primary Care Physician must be selected**

**Section III: Benefit Election - Waiving Medical Coverage (if applicable)**  
 Verification of Other Coverage is required. Enter \$88.13 on Line D. D. \_\_\_\_\_

**Section IV: Benefit Election - Vision Coverage (Vision included with Keystone Plans)**  
 Enter monthly amount on Line E.

<u>Single</u>	<u>Two-Person</u>	<u>Family</u>
\$2.93	\$7.63	\$7.63

E. \_\_\_\_\_

**Section V: Flexible Spending Accounts**  
 Enter monthly amount on Line F and/or Line G.

Medical Expenses	Maximum of \$250/month or \$3000/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 from November 1, 2009 through October 31, 2010, unless my family status changes.

Signature \_\_\_\_\_ Date \_\_\_\_\_ (PT)