



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	\$ 25.98	\$ 5.14	\$ 149.34	\$ 206.41	A. _____ Salary Under \$40,000 Enter Monthly Cost
Employee & Child	\$ 86.04	\$ 49.12	\$ 424.01	\$ 535.93	
Employee & Children	\$ 86.04	\$ 49.12	\$ 545.24	\$ 668.31	
Couple	\$ 127.04	\$ 79.16	\$ 555.42	\$ 699.63	
Family	\$ 178.29	\$ 116.72	\$ 386.46	\$ 541.67	

***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	\$ 51.95	\$ 31.11	\$ 175.31	\$ 232.38	B. _____ Salary Between \$40,000 - \$79,999 Enter Monthly Cost
Employee & Child	\$ 132.04	\$ 95.12	\$ 470.01	\$ 581.93	
Employee & Children	\$ 132.04	\$ 95.12	\$ 591.24	\$ 714.31	
Couple	\$ 186.71	\$ 138.83	\$ 615.09	\$ 759.30	
Family	\$ 255.03	\$ 193.46	\$ 463.20	\$ 618.41	

***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	\$ 77.93	\$ 57.09	\$ 201.29	\$ 258.36	C. _____ Salary Over \$80,000 Enter Monthly Cost
Employee & Child	\$ 198.06	\$ 161.14	\$ 536.03	\$ 647.95	
Employee & Children	\$ 198.06	\$ 161.14	\$ 657.26	\$ 780.33	
Couple	\$ 280.06	\$ 232.18	\$ 708.44	\$ 852.65	
Family	\$ 382.55	\$ 320.98	\$ 590.72	\$ 745.93	

***Primary Care Physician must be selected**

Section III: Benefit Election - Waiving Medical Coverage (if applicable)
 Verification of Other Coverage is required. Enter \$176.26 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
Dependent Day Care Expenses	Maximum of \$416.66/month or \$5000/year

F. _____
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 _____ (FT)