

# VASSAR BENEFITS OPEN ENROLLMENT *for* 2010

- ✘ Use this form to tell us what you want for calendar year 2010. ✘ Send to Benefits, Box 718, by December 4, 2009.
- ✘ Even if you want **no changes**, please return this to show that you have reviewed your current benefit choices.
- ✘ All changes will take effect January 1, 2010. ✘ Questions about your benefits? Call us at 5850 or stop by Baldwin, 3<sup>rd</sup> floor.

Your Name (Please Print:) ..... ID #:.....

## HEALTH INSURANCE

F/AD

- Keep me enrolled in my current health plan with no changes. (MVP HMO members must choose a new plan.)
- I don't currently have or need Vassar health insurance. I request the \$400 cash-out payment in January.
- Disenroll me from Vassar's health insurance, and provide me with the \$400 cash-out payment in January.
- Enroll me in a new health insurance plan for January 1: (Choose one)  
\_\_\_\_ Empire Blue Cross PPO \_\_\_\_ Empire Blue Cross EPO Use the health insurance enrollment form, over → →
- Add or drop family members on my current health plan. Use the health insurance enrollment form, over → →

## DENTAL INSURANCE

*Skip this section if you neither have nor want dental insurance.*

- Keep me enrolled with my current dental coverage with no changes. I have reviewed the rate information for 2010.
- Cancel my dental insurance effective December 31, 2009.
- Enroll me in the dental plan for the first time, effective January 1, 2010. Use the dental enrollment form, over → →
- Add or drop family members from my dental plan. Use the dental enrollment form, over → →

*The following are other OPTIONAL benefits. Select the benefits you want; SKIP sections for benefits you do not want.*

## LIFE INSURANCE

*You purchase this coverage through payroll deduction – see rates online.*

I want additional life insurance in the amount of:  ONE  TWO  THREE  FOUR times my annual salary, rounded to the nearest \$10,000. Complete and return the Voluntary Life Enrollment Application: see Benefits staff

- I want dependent life insurance (If you select dependent coverage, you must also select additional life insurance above.)

## SRA: SAVE FOR RETIREMENT

*You can have both a TIAA-CREF and a Fidelity SRA if you like. See online for investment information, including default option.*

- I have a TIAA-CREF SRA. Please **change** my SRA deduction amount to \$ \_\_\_\_\_ per paycheck.
- I have a Fidelity Investments SRA. Please **change** my SRA deduction amount to \$ \_\_\_\_\_ per paycheck.
- I would like to **open** a TIAA-CREF SRA and contribute \$ \_\_\_\_\_ per paycheck.
- I would like to **open** a Fidelity Investments SRA and contribute \$ \_\_\_\_\_ per paycheck.

## FLEX SPENDING ACCOUNTS

- I want a Medical Flex Spending Account. Total ANNUAL amount (\$10,000 maximum): \_\_\_\_\_
- I want a Dependent Child Care Flex Spending Account. Total ANNUAL amount (\$5,000 maximum): \_\_\_\_\_
- I want a Transit Flex Spending Account. Total MONTHLY amount (\$230 maximum): \_\_\_\_\_
- I want a Parking Flex Spending Account. Total MONTHLY amount (\$230 maximum): \_\_\_\_\_

**SIGNATURE** I want my benefits changed or continued as I have shown above, and I authorize any associated paycheck deductions. I have reviewed plan and rate information for 2010.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## Vassar College Health Plan Enrollment/Change Form

### Effective Date: January 1, 2010

*Use the Open Enrollment form on reverse to choose a health plan, then complete this chart.*

Your Name: .....

Address: ..... City:..... State:..... Zip:.....

Social Security #: ..... Birthdate: .....

Type of coverage you want:  Single  Two Adult  Family  Single Parent with Child(ren)

Add Spouse/partner name: ..... Birthdate:..... Social Security #:.....  
 Drop

Add Child name: ..... Birthdate:..... Social Security #:.....  
 Drop

Add Child name: ..... Birthdate:..... Social Security #:.....  
 Drop

Add Child name: ..... Birthdate:..... Social Security #:.....  
 Drop

*Children can be covered on your plan until age 23, whether or not they are students. Social Security numbers are required for Federal auditing of Medicare claims.*

## Vassar College Dental Plan Enrollment/Change Form for January 1, 2010

Your Name (Please Print) : .....

Address: ..... City:..... State:..... Zip:.....

Social Security #: ..... Birthdate: .....

Type of coverage you want:  Single  Family

Add Spouse/partner name: ..... Birthdate:.....  
 Drop

Add Child name: ..... Birthdate:.....  
 Drop

Add Child name: ..... Birthdate:.....  
 Drop

Add Child name: ..... Birthdate:.....  
 Drop

Add Child name: ..... Birthdate:.....  
 Drop