

Seminole State College of Florida 2010 Open Enrollment Benefits Election Form

Only complete form if requesting changes
in benefits for calendar year 2010

Name (Print) _____
EMPLID# _____

Effective Date of Coverage: January 1, 2010

Deduction Begin Date: December 2009 for insurances and January 2010 for Flex plan.

◆ HEALTH Insurance	Monthly Premium
PLAN A PPO BlueOptions (Network Blue) #3562	
<input type="checkbox"/> Employee (EE) Only	\$474.00 College Paid
<input type="checkbox"/> EE + Spouse	\$396.00
<input type="checkbox"/> EE+ (1-2)Child(ren)	\$276.00
<input type="checkbox"/> EE+ (3-4) Children	\$373.00
<input type="checkbox"/> EE+ (5 or more) Children	\$655.00
<input type="checkbox"/> EE+ Family	\$655.00
<input type="checkbox"/> EE+ Domestic Partnership – coverage rates same as above	
PLAN B BlueCare HMO (Network BlueCare) #10	
<input type="checkbox"/> Employee (EE) Only	\$495.00 College Paid
<input type="checkbox"/> EE + Spouse	\$413.00
<input type="checkbox"/> EE+ (1-2)Child(ren)	\$289.00
<input type="checkbox"/> EE+ (3-4) Children	\$388.00
<input type="checkbox"/> EE+ (5 or more) Children	\$684.00
<input type="checkbox"/> EE+ Family	\$684.00
<input type="checkbox"/> EE+ Domestic Partnership – coverage rates same as above	
PLAN C HDV Plan (not health insurance)	
<input type="checkbox"/> Employee (EE) Only	\$111.00 College Paid
Hospital Indemnity, Dental (MetLife), Vision (MetLife)	
PLAN D PPO & HRA BlueOptions (Network Blue) #3359	
<input type="checkbox"/> Employee (EE) Only	\$457.00 College Paid
<input type="checkbox"/> EE + Spouse	\$328.00
<input type="checkbox"/> EE + 1 Child	\$328.00
<input type="checkbox"/> EE + 2 Children	\$523.00
<input type="checkbox"/> EE+ (3-4) Children	\$523.00
<input type="checkbox"/> EE+ (5 or more) Children	\$523.00
<input type="checkbox"/> EE + Family	\$523.00
<input type="checkbox"/> EE+ Domestic Partnership – coverage rates same as above	
PLAN E ECO PPO BlueOptions (Network Blue) #3566	
<input type="checkbox"/> Employee (EE) Only	\$437.00 College Paid
<input type="checkbox"/> EE + Spouse	\$365.00
<input type="checkbox"/> EE+ (1-2) Child(ren)	\$254.00
<input type="checkbox"/> EE+ (3-4) Children	\$344.00
<input type="checkbox"/> EE+ (5 or more) Children	\$603.00
<input type="checkbox"/> EE+ Family	\$603.00
<input type="checkbox"/> EE+ Domestic Partnership – coverage rates same as above	

◆ HEALTH Insurance	Monthly Premium
PLAN F Dependents-Only PPO BlueOptions #3361 (Network Blue)	
<input type="checkbox"/> Employee – Indicate the plan you will be enrolled in for CY 2010: _____ (must be plan A,B,C,D, or E). Dependents in Plan F:	
<input type="checkbox"/> Spouse	\$317.00
<input type="checkbox"/> (1-2)Child(ren)	\$221.00
<input type="checkbox"/> (3-4) Children	\$299.00
<input type="checkbox"/> (5 or more) Children	\$524.00
<input type="checkbox"/> Spouse + Child(ren)	\$524.00
<input type="checkbox"/> Domestic Partnership – coverage rates same as above	

◆ DENTAL Insurance	Monthly Premium
United Concordia (Network: Advantage Plus)	
<input type="checkbox"/> Employee (EE) Only	\$26.98 College Paid
<input type="checkbox"/> EE + Dependents	\$40.45
Plan C – HDV Plan Participants ONLY	
If you enroll in Plan C, your dental plan will be the Consortium MetLife dental plan for 2010. This is a College-paid plan. You will not be enrolled in the College's United Concordia dental plan.	
<input type="checkbox"/> EE + Dependents	\$40.45
If you enroll in Plan C and elect dental for your dependents, you will be in both the Consortium (MetLife) and the United Concordia dental plans. Your dependents will be covered in United Concordia only.	

◆ VISION Insurance	Monthly Premium
Humana CompBenefitsVision Care Plan	
<input type="checkbox"/> Employee (EE) Only	\$ 6.50
<input type="checkbox"/> EE + Family	\$ 18.60
<input type="checkbox"/> Waive employee-paid vision insurance	

◆ Flex Spending
Account Type
<input type="checkbox"/> Healthcare Reimbursement Account (FSA)
<input type="checkbox"/> Dependent Care Reimbursement (FSA)
<input type="checkbox"/> Request FSA Debit Card (Training for card mandatory)
<input type="checkbox"/> Waive employee-paid Healthcare and Dependent Care (FSA) Accounts
<input type="checkbox"/> Decline pre-tax benefits of Flex plan for EE paid premiums

Life Insurance	Monthly Premium
Standard Life Insurance Options	
<input checked="" type="checkbox"/> Basic Life & AD & D	College Paid
<input type="checkbox"/> Additional Term Life/AD&D	\$0.277/\$1,000 1X, 2X, or 3X annual salary (please circle one)
<input type="checkbox"/> Waive employee-paid additional term life	
<input type="checkbox"/> Dependent Life (please circle option A or B)	
Option A- Spouse \$20,000, Child(ren) \$10K	\$5.00
Option B -Spouse \$10,000, Child(ren) \$5K	\$2.50
<input type="checkbox"/> Waive employee-paid dependent life	

Disability Insurance	Monthly Premium
UNUM Life Insurance 60 Day Initial Hire Option	
<input type="checkbox"/> Long-Term Disability	Age-rated
<input type="checkbox"/> Waive employee-paid long-term disability	

Important Reminders
You must submit this form along with enrollment forms for health, dental, vision, Flex, life, and disability plans.

Remember to submit Prior/Concurrent Coverage Affidavit for pre-existing condition waiver for PPO Plans.

Authorization
I authorize the elections made and any payroll deductions required for such elections.
◆ I understand that election changes can only take place during Open Enrollment for health, dental, vision, and Flex plans, unless a qualifying event occurs. Qualifying events have been explained to me.

Employee Signature _____

Date _____