NAME _____

ID NUMBER _____

BRYN MAWR COLLEGE
FLEXIBLE BENEFIT ELECTION FORM
PLAN YEAR NOVEMBER 2024 TO OCTOBER 2025

EFFECTIVE DATE _____

EMPLOYEE: COMPLETE SECTIONS 1-5. Please see rate sheet for all monthly costs.

SECTION 1: MEDICAL PLAN *(Select one plan and one coverage level.)*

PERSONAL CHOICE PPO	☐	SINGLE	☐
PERSONAL CHOICE PPO HIGH DEDUCTIBLE	☐	PARENT & CHILD(REN)	☐
KEYSTONE POS	☐	EMPLOYEE & SPOUSE	☐
KEYSTONE HMO	☐	FAMILY	☐

WAIVE (SEE SECTION 4) ☐

SECTION 2: DENTAL (*Single coverage is an employer-paid benefit. Select a coverage level only if enrolling dependents.)*

SINGLE	X	PARENT & CHILD	☐
		PARENT & CHILDREN	☐
		EMPLOYEE & SPOUSE	☐
		FAMILY	☐

SECTION 3: SUPPLEMENTAL LIFE INSURANCE *(Select "Waive" if receiving only the employer-paid basic benefit of $50,000. Employee and Spouse Elections are in increments of $10,000.)*

		COVERAGE AMOUNT
EMPLOYEE	birthdate ___/___/___	_____
SPOUSE	birthdate ___/___/___	_____
CHILD(REN)		_____

WAIVE ☐ ***NO CHANGES*** ☐

SECTION 4: MEDICAL INSURANCE WAIVER

IN ORDER TO WAIVE MEDICAL COVERAGE, CERTIFICATION OF GROUP MEDICAL INSURANCE COVERAGE IN FORCE ELSEWHERE FOR THE EMPLOYEE IS REQUIRED. PLEASE COMPLETE THE INSURANCE INFORMATION BELOW. PLEASE PRINT.

Name of Insurance Company _____ **Policy /Group #**_____

Policyholder/Employer _____ **ID #** _____

SECTION 5: SUMMARY

I wish to become insured for the coverage chosen as evidenced by my signature below and agree to the following:

1. I authorize the above selections and, any pre-tax and/or after-tax reductions in pay, as specified on the rate sheet.
2. I understand that insurance applications are requested for each plan in which I enroll and must be submitted by the due date to ensure enrollment.
3. I understand that if I waive medical coverage, the subsidy that I receive is fully taxable.
4. I understand that I cannot change or revoke these elections unless that change or revocation is on account of and consistent with a life event change in status.

SIGNATURE _____ **DATE** _____

Life Event Change Date _____

☐ Marriage ☐ Divorce ☐ Birth/Adoption ☐ Loss of other group coverage ☐ Enrollment in other group coverage ☐ Other _____

EMPLOYEE: PLEASE KEEP A COPY FOR YOUR RECORDS