

2008 BENEFITS ENROLLMENT FORM
Medical Residents

EMPLOYEE INFORMATION: PLEASE COMPLETE ENTIRE SECTION (TYPE OR PRINT LEGIBLY)
NEW HIRES MUST RETURN THE COMPLETED BENEFITS ENROLLMENT FORM
NO LATER THAN 2 WEEKS FROM THE DATE OF THEIR SCHEDULED UNIVERSITY ORIENTATION

Last	First	Date of Birth
GWID or SSN	Date of Hire	Employment Status <input type="checkbox"/> FT <input type="checkbox"/> PT
Street	Salary	Pay Frequency <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly
City	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
State/Zip Code	Home Phone	Daytime/Office Phone

MEDICAL

Please select one option below. If you select coverage other than Employee Only, you must provide dependent information in the Dependents Section of this form. If you have Medicare or coverage from another source and do not wish to enroll, please select Waive Coverage.

CareFirst PPO

Employee Only Employee + One Employee + Family

CIGNA HMO*

Employee Only Employee + One Employee + Family

CIGNA POS *

Employee Only Employee + One Employee + Family

Waive Coverage

* If you elect the **CIGNA HMO** or the **CIGNA POS**, you must select a Primary Care Physician (PCP) and provide the PCP identification number here:

DENTAL

Please select one option below. You may elect dental coverage even if you do not have medical coverage. If you do not make an election, you will not have dental coverage.

Aetna High Option

Employee Only Employee + One Employee + Family

Aetna Low Option

Employee Only Employee + One Employee + Family

Aetna DMO

Employee Only Employee + One Employee + Family

Waive Coverage

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DEPENDENTS									
You may cover your spouse or domestic partner and/or dependent children under the medical and dental plans. Please complete the information below for each individual you wish to cover (or delete from coverage). Be sure to check one or both plans, as applicable.									
Option	SSN	Name	Sex	DOB	Relationship	Student/ Disabled*	Medical	Dental	
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> PCP #	<input type="checkbox"/>	
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> PCP #	<input type="checkbox"/>	
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> PCP #	<input type="checkbox"/>	
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> PCP #	<input type="checkbox"/>	
* Complete only for children age 19 or older, add additional sheet if necessary.									

FLEXIBLE SPENDING ACCOUNTS (FSAs)	
You may contribute a maximum of \$5,000 a year to a Health or Dependent Care FSA (\$2,500 if married filing separately); \$100 minimum for Health & Dependent Care FSAs . To take advantage of savings offered through the FlexFund(s) , you must enroll or re-enroll annually. For 2008, you have until March 15, 2009, to incur eligible healthcare expenses. You will have until April 30, 2009, to submit claims for services. The March 15 th deadline period does not apply to the Dependent Care Account. For 2008, you have until December 31, 2008, to incur eligible dependent care expenses.	
Account	Annual Contribution
Health Care FSA	\$
Dependent Care FSA	\$

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SUPPLEMENTAL GROUP TERM LIFE INSURANCE

Basic Life Insurance is provided in amounts equal to one (1) times your annual salary to a maximum benefit of \$50,000. If the volume of your Basic Life Insurance exceeds \$50,000, you have the option of limiting your coverage to \$50,000 in order to avoid imputed income tax, however, if at a later eligibility opportunity you would like to elect more you will be required to show proof of insurability. **To request an Evidence of Insurability form, call 202-994-9600.**

In addition, you may purchase Supplemental Group Term Life Insurance through UnumProvident in increments of \$10K, up to 5x your salary (the amount chosen will be rounded up or down to the nearest tenth). The maximum amount of coverage is \$750,000 and the dollar amount of coverage and cost will vary as your salary changes.

SUPPLEMENTAL GROUP TERM LIFE FOR FULL-TIME AND PART-TIME EMPLOYEES

Employee and Spouse and Domestic Partner *		Child *
Age Band	Monthly Rate per \$1,000 of Coverage	Monthly Rate per \$1,000 of Coverage
<19	\$.040	\$.103
20 – 24	\$.050	
25 – 29	\$.050	*NOTE: The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.
30 – 34	\$.050	
35 – 39	\$.080	
40 - 44	\$.120	
45 – 49	\$.220	
50 – 54	\$.390	
55 – 59	\$.660	*NOTE: Employee and Spouse , your rate will increase as you age and move to the next age band.
60– 64	\$.900	
65 – 69	\$1.62	
70 - 74	\$2.15	
75+	\$2.44	

PLEASE PRINT LEGIBLY

Add Delete Employee Coverage Amount \$ _____ (in increments of \$10,000)

DEPENDENT LIFE INSURANCE

If you elect Supplemental Group Term Life Insurance for yourself, you can also buy life insurance for your spouse or domestic partner and/or dependent children in the amounts listed below. Coverage for your spouse or domestic partner cannot be greater than 50% of your Supplemental Group Term Life Insurance. You are the automatic beneficiary for any Dependent Life Insurance you purchase. PLEASE PRINT LEGIBLY

Add Delete Spouse, Coverage Amount \$ _____ (in increments of \$5,000)
(maximum of \$375,000)

Add Delete Domestic Partner, Coverage Amount \$ _____ (in increments of \$5,000)
(maximum of \$375,000)

Add Delete Child(ren), Coverage Amount \$ _____ (in increments of \$2,000)
(maximum of \$10,000)

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OTHER PROGRAMS

You can elect to participate in one or both of the programs listed below. Details about the programs, including costs, are available online.

If you want to participate in these programs, you must ENROLL ONLINE.

Program	Provided By	Description	To Learn More and/or Enroll
Long-Term Care (LTC) Insurance	UnumProvident (administered by Todd Benefits Group)	Covers a wide range of personal care services for people unable to care for themselves.	www.toddltc.com/gw05
Legal Resources Program	Legal Resources	Provides a variety of legal services (e.g., real estate, consumer disputes, credit problems, wills). Note: You must remain in the plan for 12 months.	www.legalresourcesplan.com ID: 0185 Password: nhlegal

TO COMPLETE YOUR ENROLLMENT

Sign and date the confirmation of your enrollment below and return your completed form to the Division of Human Resources Benefits Administration Department at 2033 K Street NW, Suite 220. Your elections will remain in effect through December 31, 2008 unless you have a **Qualified Life Event (QLE)**. Please contact Benefit Administration for more information about QLEs.

CONFIRMATION OF ENROLLMENT

I understand that:

- The information provided above is true and correct to the best of my knowledge.
- The coverage will become effective according to GW's eligibility guidelines following approval of this application.
- Should any material answers or statements contained in this application be untrue, then the coverage may be cancelled and I will be subject to disciplinary action up to and including termination. Further, I may be required to repay payments made in error to me or on my behalf or on behalf of any covered family member as the result of the erroneous information.
- I authorize any provider to forward to the carrier information concerning medical services or supplies provided to me or to any of my family members listed on this application for the purpose of review, investigation or payment of a claim. This authorization is valid for the duration of the coverage.
- A copy of this application is available to the subscriber (or a person authorized to act on his/her behalf) upon request.
- Any person who with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive information may be guilty of insurance fraud.

- I hereby apply for the group benefit(s) indicated above.
- I understand I must be actively at work or my life insurance coverage will not take effect until I have returned to active employment.
- I authorize my employer to take deductions from my pay on a pre-tax or post-tax basis as described in the enrollment material.
- I understand that my elections cannot be changed or terminated during the plan year, unless there is a change in my family status called a Qualified Life Event (e.g., marriage, divorce, birth or adoption of child). Any changes made as a result of a Qualified Life Event must be consistent with that event.

Signature	Date	E-Mail Address
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OFFICE USE ONLY

Effective Date	Keyed	Mailed
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