

**The George Washington University
Benefit Services Division
Open Enrollment/Change Worksheet for Regular Employees
2006 Plan Year**

Please use this form to:

- o Enroll in/Change the University's medical, dental, and group term life insurance plans
- o Enroll in flexible spending accounts for 2006
- o Enroll in the pre-paid legal services plan
- o Add/delete dependents

Return the form to the Benefit Services Office at 2033 K Street NW Suite 220 no later than **Monday, November 14, 2005**. Keep in mind that the elections you make become effective January 1, 2006 and will remain in effect until December 31, 2006, unless you have a qualified life event (QLE). Please contact Benefit Services for a QLE description.

Employee Information: Please complete entire section

Name:	SSN:	DOB:
Street:	Date of Hire:	Status: <input type="checkbox"/> FT <input type="checkbox"/> PT
City:	Annualized Salary:	Pay Frequency: <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly
State/Zip Code:	Gender (M/F):	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married
Home Phone:	Office Phone:	

Medical:

Please select one option below. If you are a Full-time Regular Faculty or Staff member and do not make an election, you automatically will be placed in the CareFirst PPO, Employee Only option. If you have Medicare or coverage from another source and do not wish to enroll please select Waive Coverage.

Options			
CareFirst PPO (R1820005 / R1820006)	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + One	<input type="checkbox"/> Employee + Family
CIGNA HMO (3157928)**	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + One	<input type="checkbox"/> Employee + Family
CIGNA POS (3157928)**	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + One	<input type="checkbox"/> Employee + Family
Waive Coverage*	<input type="checkbox"/>		

NOTE: If you select coverage other than Employee Only you MUST provide dependent information in the Dependents section of this enrollment worksheet.

* If you select this option you will have no medical coverage through GW. You will not be able to elect coverage until the next open enrollment unless you have a qualified life event.

** If you choose this option you must select a Primary Care Physician (PCP) and provide the PCP identification number: _____
(PCP Identification Number)

Dental:

Please select one option below. If you do not make an election, you will not have dental coverage. Please see the online enrollment guide at gwu.edu/~hrs/benefits/open enrollment for waiting periods for certain benefits.

Options				
Guardian High Option	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Child	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Family
Guardian Low Option	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Child	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Family
No Coverage*	<input type="checkbox"/>			

* If you select this option you will have no dental coverage through GW. You will not be able to elect coverage until the next open enrollment unless you have a qualified life event.

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Dependents:

You may cover your spouse or same sex domestic partner and dependent children under the medical and dental plans. Please complete the information below for each individual you wish to cover and indicate the plans in which he or she will participate.

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"/> PCP# _____	<input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> PCP# _____	<input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F				PCP# _____	<input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F				<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"/> PCP# _____	<input type="checkbox"/>
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> PCP# _____	<input type="checkbox"/>

*Complete only for children age 19 or older.

Flexible Spending Accounts (FSA):

- You may contribute up to \$5,000 per year for the Medical Care FSA .
- If you are a single parent or a married couple filing a joint return you may contribute up to \$5,000 (\$2,500 if married filing separately) for the Dependent Care FSA.

NOTE: Funds must be used for eligible expenses incurred from January 1, 2006 through March 15, 2007. Unused funds will be forfeited. If you do not make an election, you will not be enrolled.

Account	Your Annual Pre-Tax Contribution
Medical Care FSA	\$
Dependent Care FSA	\$

Once enrolled, elections cannot be changed unless you have a Qualifying Life Event (QLE).

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2006 Plan Year**

Pre-Paid Legal Services:

You may elect to participate in the pre-paid legal services plan through Legal Resources. Cost for the plan is \$18 per month plus a one-time enrollment fee of \$20. You must remain in the plan for at least 12 months. Please consult your enrollment guide for details.

Participate

Do Not Participate

If participating, please indicate the Legal Office you wish to choose: _____

NOTE: This benefit can only be terminated at the first Open Enrollment following your one-year anniversary, or at subsequent Open Enrollments.

Group Term Life Insurance:

GW provides you with Group Term Life Insurance equal to your annual salary. You do not pay a premium for this coverage. Imputed income is calculated on amounts in excess of \$50,000. **If you wish to avoid imputed income and limit your coverage to \$50,000 please check here.**

Keep in mind that if you wish to increase coverage in the future, you will need to provide Evidence of Insurability (EOI).

In addition, you may elect additional Group Term Life in the amounts listed below.

Employees may elect additional term life at any time. EOI is required for entire coverage amount if election is not within 30 days of hire date. Your coverage will not go into effect until we receive approval from the insurer.

The maximum amount of coverage is \$750,000.

The dollar amount of your coverage and your cost will change as your salary changes.

Amount of Coverage	Selection
No Additional Coverage	<input type="checkbox"/>
25% of Salary	<input type="checkbox"/>
50% of Salary	<input type="checkbox"/>
1x Salary	<input type="checkbox"/>
2x Salary	<input type="checkbox"/>
3x Salary	<input type="checkbox"/>
4x Salary	<input type="checkbox"/>
5X Salary	<input type="checkbox"/>

Age	Rate per \$1000	Age	Rate per \$1000
<30	\$0.05	55-59	\$0.78
30-34	\$0.06	60-64	\$1.07
35-39	\$0.09	65-69	\$1.93
40-44	\$0.14	70-74	\$2.56
45-49	\$0.26	75+	\$2.91
50-54	\$0.46		

Beneficiary:

Please indicate the beneficiary(s) for **your** life insurance along with the percentage of the benefit they are to receive.

Primary	Relationship	Percentage/Flat Amount:
Name:		
Name:		
Contingent		
Name:		
Name:		

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Dependent Life:

You may also select coverage for your spouse/same sex domestic partner and dependent children. Please indicate the amount of coverage you wish to elect below. **You must elect additional Group Term Life for yourself to be eligible for this benefit. The employee is the automatic beneficiary for the Spouse/Domestic Partner and Child Life policies.**

Coverage for your spouse/domestic partner cannot be greater than 50% of your supplemental coverage.

Spouse/Domestic Partner

Amount of Coverage	Selection
No Coverage	<input type="checkbox"/>
\$10,000	<input type="checkbox"/> *
\$15,000	<input type="checkbox"/> *
\$25,000	<input type="checkbox"/> *

Child(ren)

Amount of Coverage	Selection
No Coverage	<input type="checkbox"/>
\$5,000	<input type="checkbox"/> \$0.62**
\$10,000	<input type="checkbox"/> \$1.23**

* Premium for Spouse/Domestic Partner Life is calculated, using the same rate table as Employee Supplemental Life, according to employee's age.
** All dependent children are covered by the Child Life policy

Confirmation of Enrollment:

Please Read Carefully, Sign, and Date:

I understand that:

- A) The information provided above is true and correct to the best of my knowledge.
- B) The coverage will become effective according to GW's eligibility guidelines following approval of this application.
- C) Should any material statements or answers 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 the behalf of any covered family member as the result of the erroneous information.
- D) 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.
- E) A copy of this application is available to the subscriber (or a person authorized to act on his/her behalf) upon request.
- F) 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: _____

Office Use Only

Effective Date	
Keyed	
Mailed	