



Open Enrollment for 2010 Benefits

This form lists benefits options and their associated monthly costs for 2010. Use this form to select coverages for 2010. Please note that your choices will remain in effect throughout 2010 unless you experience a qualifying change in family status.

Your completed enrollment form must be received by the Benefits Office no later than 5:30 p.m. on Thursday, October 15, 2009. You may drop off your form to 2525 West End Avenue, Suite 502 from 7:30 a.m. to 5:30 p.m. on October 15 or Oxford House, Room 1010 from 8 a.m. to noon on October 15.

Please keep a copy of the completed form for your records.

Employee ID or Social Security Number Last Name First Name M.I. Date of Birth
Home Mailing Address City State Zip

PRICE AND (OPTION CODES)

Prices shown are monthly amounts.

Medical

Table with 5 columns: Plan Name, Employee Only, Employee + Spouse/Partner, Employee + Children, Employee + Family, Option Code #. Rows include Aetna Standard, Aetna Standard Partner\*, Aetna HealthFund, Aetna HealthFund Partner\*, BlueCross Advantage P, BlueCross Advantage P Partner\*, Waive\*.

Dental

Table with 5 columns: Plan Name, Employee Only, Employee + Spouse/Partner, Employee + Children, Employee + Family, Option Code #. Rows include CIGNA Dental PPO, CIGNA Dental PPO Partner\*, CIGNA Dental Care (DHMO), CIGNA Dental Care (DHMO) Partner\*, Waive.

Vision

Table with 5 columns: Plan Name, Employee Only, Employee + Spouse/Partner, Employee + Children, Employee + Family, Option Code #. Rows include Eye Care Pre Tax, Eye Care Pre Tax Partner\*, Waive.

Accidental Death & Dismemberment

Price per \$10,000 of coverage (up to \$500,000)

Table with 5 columns: Plan Name, Price per \$10,000, Option Code #, AD&D Coverage Amount \$. Rows include AD/D Individual, AD/D Family, Waive.

AD&D maximum coverage is 10 times your annual salary or \$500,000, whichever is less.

Flexible Spending Accounts

To enroll in a Flexible Spending Account (FSA) for 2010, you must make elections on this form.

DO NOT complete this section of the form if your date of hire is after 10/1/09. Contact Human Resources for a separate FSA Enrollment Form.

FSA Options:

- 1. Health FSA (use this account for medical expenses for you and all your tax dependents)
Minimum Annual Contribution \$104.00
Maximum Annual Contribution \$3,600.00\*\*
Health FSA Annual Amount \$
2. Dependent Care FSA (use this account for child care or custodial care so that you can work)
Minimum Annual Contribution \$104.00
Maximum Annual Contribution \$5,000.00\*\*
Dependent Care FSA Annual Amount \$

**Current Covered Dependents**

In this box list all dependents that will have Health, Dental and/or Vision coverage. Eligible dependents are restricted to your spouse or certified domestic partner, and qualified dependent children. Write "Yes" or "No" in the column to indicate whether you and your dependents will be covered under the health, dental and/or eye care plans.

Name	Health	Dental	Vision
Employee:			
Spouse:			
Child:			
Child:			
Child:			
Child:			

**New Dependents**

Please identify **new** dependent information in the spaces provided below. Social Security Numbers and birthdates are required. Please provide all of the requested information to avoid a delay in processing. Do not add any dependents who are not eligible for coverage under the guidelines in the Vanderbilt Health Care Plan for Faculty and Staff. Review eligibility guidelines online by looking in the Health Care summary plan description (<http://hr.vanderbilt.edu/forms>). Place a check in the column (health, dental or vision) for the coverage you want for the new dependent. Documentation of dependent status may be requested.

Dependent Name	Relationship	SSN	Date of Birth	Sex	Health	Dental	Vision

**Disclaimer**

The Health Care, Dental, Vision, Accidental Death & Dismemberment and Flexible Spending Account Plans (the Plans) generate, receive and maintain records that contain health information about you to administer the Plans and provide you with benefits. By signing below you authorize health care providers and plan administrators to disclose your medical information during the period of time you are covered by the Plans as needed for the proper and effective administration of the Plans including, but not limited to, for the processing of claims for the period of fourteen (14) months from the date of your acceptance to and enrollment in the plans. Social Security Numbers must be provided for those covered by the Plans solely for the purpose of uniquely identifying the patient in order to pay claims.

**Notification Declaration**

I have read and understand the following notices provided to me in the Open Enrollment materials sent to my home address or viewed online:

- Women's Health & Cancer Rights
- Medicare Part D
- COBRA information in anticipation of divorce
- Privacy Rights

(To review these notices online, go to <http://hr.vanderbilt.edu/benefits/oe.htm>)

**Signature of employee:**

I understand that coverage does not become effective until accepted by Vanderbilt University and by the provider. Further, I have received information about Vanderbilt's benefits program and I authorize appropriate deductions from my earnings to the extent that I am responsible for payment of premiums. I declare I am eligible to enroll in these Plans and request coverage. I hereby declare that, to the best of my knowledge and belief, information given on this enrollment form is correctly recorded, complete and true. I understand that giving false information will result in loss of my benefits and possible loss of employment.

I understand if I choose to waive health coverage beginning January 1, 2010, I need to submit a completed Health Plan Waiver to the Benefits Office attached to this enrollment form. Link to form: <http://hr.vanderbilt.edu/benefits/documents/HealthPlanWaiver.pdf>.

I understand if I choose partner coverage I must certify my same-gender domestic partnership\* prior to December 31, 2009. (Contact the Benefits Office to schedule a certification meeting.)

Signature \_\_\_\_\_ Date \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Evening phone \_\_\_\_\_

Work E-mail: \_\_\_\_\_ Home E-mail: \_\_\_\_\_

\*Additional documentation required.

\*\*Each employee can have a maximum of \$3,600 for Health FSA. The maximum per household for Dependent Care FSA is \$5,000.