Hope COLLEGE

Initial Benefits Enrollment Form

All employee contributions applicable to the benefits elected below will be withheld pre-tax, semi-monthly (unless otherwise noted).

Employee Last Name:	**Employee First Name :**
Address:	**City, State ZIP:**
Employee SSN:	**Employee Birthdate (MM/DD/YYYY):**
Employee Gender: ◯ **Male** ◯ **Female**	**Employee Marital Status:** ◯ **Single** ◯ **Married**

Health & Pharmacy *(effective date is date of hire/eligibility) Benefit ID will be mailed to address above within 7-14 days if enrolling.*

Plan Choice:
◯ BLUE Traditional Plan (#141) *(affordable monthly cost, low out of pocket cost)*
◯ ORANGE High Deductible Health Plan (#140) *(very low monthly cost; higher out of pocket cost)*
◯ Waive Coverage (#149) *(no cost)*

Level of Coverage: ◯ Employee Only ◯ Employee + 1 Family Member ◯ Employee + 2 or More Family Members

Dental *(effective date is date of hire/eligibility). Benefit ID will be mailed to address above within 7-14 days if enrolling.*

Plan Choice: ◯ Basic Dental Plan (#125) ◯ Dental Plan w/ Ortho Coverage for Dep <age 19 (#125) ◯ Waive Coverage (#129)

Level of Coverage: ◯ Employee Only ◯ Employee + 1 Family Member ◯ Employee + 2 or More Family Members

Vision *(effective date is the first of the month following date of hire/eligibility. Benefit ID will be mailed to address above within 7-14 days if enrolling.*

Plan Choice: ◯ Insight Vision Plan (#126) ◯ Waive Coverage (#116)

Level of Coverage: ◯ Employee Only ◯ Employee + 1 Family Member ◯ Employee + 2 or More Family Members

Health, Dental, & Vision Plan Family Members. Be sure to check the appropriate boxes for the coverages you elect for your dependents; you may add any additional dependents on another form if needed.

	First Name	Last Name	SSN	Date of Birth	M/F	Relationship	Health & Pharmacy	Dental	Vision
Spouse*							☐	☐	☐
Dep-1							☐	☐	☐
Dep-2							☐	☐	☐
Dep-3							☐	☐	☐
Dep-4							☐	☐	☐
Dep-5							☐	☐	☐
Dep-6							☐	☐	☐
Dep-7							☐	☐	☐

***Spouse's Employment Status and Employer Information (if applicable)**: *(#124)*

◯	Not Employed *(surcharge does not apply)*
◯	Employed but no health benefits available through employer *(surcharge does not apply)*
◯	Self Employed with no health benefits available to any employees including self *(surcharge does not apply)*
◯	Employed with primary coverage through employer *(surcharge does not apply)*
◯	Spouse employed at Hope College *(surcharge does not apply)*
◯	Employed with health benefits available but not elected *(surcharge applies)*

Spouse's Employer's Name	Address	Phone Number

FSA/HSA Tax Savings Accounts (pre-tax):

FSA account benefit dates are July 1 (or date of hire/eligibility, if later) – June 30 each benefit year. *All FSA Accounts annual elections will be split and deducted from all pays (24 or those remaining) in benefit year following enrollment. PNC Bank will email you additional enrollment instructions to complete your account setup.*

☐ Decline to Participate	☐ Flexible Medical Account *(Must be enrolled in Traditional Medical Plan ~ BLUE)* ($3200 2024/25 Benefit Year Max.) **ANNUAL** Amount:_____	☐ Health Savings Account *(Must be enrolled in HDHP Medical Plan ~ ORANGE)* ($4150*/Single or $8300*Dbl/Fam Calendar Year Max.) *If 55 or older, +1,000 catchup allowed **PER PAY** Amount: _____	☐ Limited Purpose Dental & Vision Flexible Account *(Must be enrolled in HSA)* ($3200 2024/25 Benefit Year Max.) **ANNUAL** Amount:_____	☐ Flexible Dependent Care Account *(No criteria to enroll; all eligible)* ($5000 2024/25 Benefit Year Max.) **ANNUAL** Amount:_____
HR USE: #139	#130	#510	#131	#135

Life/Accidental Death & Dismemberment & Long Term Disability Insurance

Effective date is date of hire/eligibility. NOTE: This benefit is not available to interns, visiting faculty, RD, or RLC employees.

Sun Life
Life's brighter under the sun

The College provides, at no cost, Basic Life Insurance equal to one and a half times annual base salary as well as Basic LTD Insurance of 60% monthly benefit (up to plan maximums) through our partner provider. Please provide **Beneficiary Designation** below which will apply to your Life and Accident coverages, including supplemental if elected below.

	Name (Last, First, MI)	Relationship	% of Benefit
Primary Beneficiary - 1			
Primary Beneficiary – 2			
Contingent Beneficiary – 1			
Contingent Beneficiary - 2			

Optional Employee Supplemental Life Insurance (after-tax) (#621 and #627)

◯ No Additional Coverage ◯ 1x ◯ 2x ◯ 3x ◯ 4x ◯ 5x ◯ 6x ◯ 7x

Coverage is offered at above factors of your base salary and will be rounded to the next higher 10,000. You must provide evidence of insurability for coverage above $200,000. Click **here** to complete EOI and submit directly to insurance company for review.

Optional Dependent Supplemental Life Insurance (after-tax)

☐ No Additional Coverage ☐ $_____ Coverage for Spouse* ☐ $10,000 Child Rider *(for all dependent children under 19)*

*Spouse coverage is available from $10,000-$250,000 in $10,000 increments, not to exceed 50% of the value of the level of Supplemental Life Insurance elected for employee. Evidence of Insurability is required for coverage above $50,000. Click **here** to complete EOI and submit directly to insurance company for review.

Optional Employee Supplemental LTD insurance (after-tax) (#628)

◯ No Additional Coverage ◯ Buy-Up (+10% monthly benefit up to plan maximums)

HR USE: #160, #185, #195, #210 if eligible. #621 & #627 if Optional Life. #628 if Optional LTD

Retirement INVEST 403(b) Plan (#395)

(Eligibility: 1) voluntary contributions date of hire 2) 10.5% college contribution 1st of month after 1 year). To setup your account and elect voluntary contributions, sign in as "new user" at hopecollege.trsretire.com once your employee information is processed (normally 7-14 days from submitting this enrollment form).

TRANSAMERICA Retirement Solutions

NOTE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

Employee Signature: **Date:**

HR USE: Effective/Change Date: ____/_____/_____ Change Reason: New Hire Open Enrollment Special Enrollment DOH: ___/___/___ Annual Salary: $_____ HRS/FTE: _____

PDAHIOC PDADEDN PDABCOV EMVP-H CM EMVP-D EM PNC LIFE/LTD

RETIREMENT: NEW HIRE =Elig after 1 Yr Svc then 1st of following month REHIRE = Eligible Immediately on DOH 2nd year Visit &/or Convert to NTT/TT = Eligible 1st of month on DOH anniversary

CURRENT (1000Hrs Before 1st Anniv) = Elig 1st Mth Following anniversary CURRENT (>12Mths& will work 1000Hrs in C/Y) = Elig following 1/1