DELTA COLLEGE BENEFITS ENROLLMENT FORM
General Laborers (MG)
PLAN YEAR: 2022

Section A - Employee Information

Employee Name:	Social Security No:
Address:	City/State/Zip:
Email Address:	Employee ID#:
Phone: Sex: Date of Hire:	Date of Birth:

Section B – Select Action (circle one)

Effective Date of Qualifying Event:

Open Enrollment	New Hire/Full-time Position	Resignation/Retirement

Birth of Child	Marriage	Divorce	Other:

Qualifying events must be communicated within 30 days to Human Resources. Failure to notify Human Resources within 30 days may cause the employee to be liable for insurance claims and college paid health, vision and dental premiums. Documentation is required for qualifying events to be processed. (Additions - marriage licenses and birth certificates. Removal - divorce decree)

Section C – Benefit Elections

Health/Vision Insurance (circle election below)

1) Decline health insurance -- Decline

2) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) and vision

	Single	2 Person	Family
20% cost share of premium	$83 / month	$200 / month	$249 / month
HSA Additional Employee Contribution Single ($3650 max) 2P/Family ($7300 max)	$ / pay	$ / pay	$ / pay

Section D – Dependent Information

Name (First, MI, Last)	Social Security #	Birth Date	M/F	Check One Add	Remove
Spouse					
Dep. 1					
Dep. 2					
Dep. 3					
Dep. 4					

COBRA NOTIFICATION ADDRESS: _____

Complete only if you are discontinuing coverage for a covered member

Section E - Authorization

I acknowledge that:

- I have reviewed Delta College's benefit plan documents for which I am enrolling.
- By signing this form, I make a binding election concerning my benefits for the plan year of January 1 – December 31, 2022.
- I understand that I will not be able to change my elections unless I have a qualifying event. (marriage, divorce, death, birth or adoption of a child, termination of employment of a spouse, or other such qualifying events allowed by the plans)
- I authorize Delta College to reduce my annual salary in accordance with my elections.
- Eligible deductions will be taken on a pre-tax basis and my social security benefits may be reduced.
- Delta College may reduce or cancel my compensation reduction or otherwise modify this agreement in the event that it is advisable in order to satisfy certain provisions of the IRS.
- I will be offered the opportunity to change my benefit elections for the following plan year during open enrollment.
- If I do not complete and return a new election form during open enrollment, these elections will remain in place for future plan years.
- Employees on a sick or FMLA leave continue to be responsible for paying their share of premiums for benefit plans. If the employee fails to pay their share of the premiums, the coverage will be terminated with prior notice.
- The primary insured/HSA account holder cannot have dual coverage. Each spouse must open a separate HSA.
- I affirm that the information provided is correct. I understand that if I submit false information, I may be held financially responsible for all claims filed and be required to reimburse the College for any payments made on behalf of or for the benefit of an ineligible dependent.

Employee Signature: _____ **Date:** _____

HUMAN RESOURCES OFFICE USE ONLY

Transfer		Benefit	Benefit Effective/Separation Date	Colleague Processed	
From:		HDHP-HSA			COBRA
To:					PREL / PBEN
			Notify Arcadia / Payroll		1095C