**Employee Benefits 2009**

**EMPLOYEE INFORMATION**

| Name: | Verify Address: |

**MEDICAL**

<table>
<thead>
<tr>
<th>Change from Previous Coverage?</th>
<th>YES □ NO □</th>
<th>Waive Medical □</th>
</tr>
</thead>
</table>

- **HMO** (If no election, HMO is default plan)
- **PPO** (Note: If PPO elected, employee will incur higher cost)

**Family Members Covered:**

- □ Employee Only
- □ Two-Person
- □ Family

**DENTAL**

<table>
<thead>
<tr>
<th>Change from Previous Coverage?</th>
<th>YES □ NO □</th>
<th>Waive Dental □</th>
</tr>
</thead>
</table>

**Family Members Covered:**

- □ Employee Only
- □ Two-Person
- □ Family

**FLEX PLAN**

<table>
<thead>
<tr>
<th>Annual amount</th>
<th>Services incurred 1/1/09-12/31/09</th>
</tr>
</thead>
</table>

- □ Health Care Reimbursement (up to $3,000)
- □ Dependent Care Reimbursement (up to $5,000)

*Complete Flex Plan Enrollment Form*

**SUPPLEMENTAL PLANS**

<table>
<thead>
<tr>
<th>Complete for Changes Only</th>
</tr>
</thead>
</table>

- □ Supplemental Life (Subject to Underwriting)
  *Complete Life Form*

- □ Supplemental Long-Term Care (Subject to Underwriting)
  *Complete Long-Term Enrollment Form*

**SIGNATURE AND ACKNOWLEDGEMENT**

I hereby elect to participate in the selected employer sponsored benefit plan(s) effective 1/1/2009. Any previous election and compensation reduction agreements relating to the same benefit are hereby revoked on 12/31/2008. I understand that I am responsible for the entire employee portion of the premium, and should an error occur I should notify Human Resources immediately. As a participant I understand that all guidelines regarding enrollment are set forth in the Summary Plan Descriptions. I also understand that this election is for the period 1/1/2009 through 12/31/2009, and can only be changed if I have experienced a qualified benefit event.

**Signature:** ___________________________  **Date:** ___________________________

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*Colby-Sawyer College*