Georgia Tech

2017 New Hire Benefits Enrollment

New Hire Start Date: _____
Benefits Election 30-Day Deadline: _____
Retirement Election 60-Day Deadline: _____

Revised 02/17/2017

Name (First, Middle Initial, Last)	Social Security Number	Department/Title	Contact Phone Number

Medical

- ☐ Comprehensive Care[1]
- ☐ Consumer Choice HSA[1,2]
- ☐ Kaiser Permanente HMO
- ☐ BlueChoice HMO[1]
  Employee PCP required, ID#: _ _ _ _ _ _ _ _ - _ _ _
- ☐ Waive Medical Coverage

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

[1]This plan is administered by BlueCross BlueShield of Ga. and uses the POS network.
[2]Not eligible for J Exchange Visitor Program.

Dental

- ☐ Delta Dental Base PPO
- ☐ Delta Dental High PPO
- ☐ Delta Dental HMO
- ☐ Waive Dental Coverage

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Delta Dental Facility HMO ID#: _____

Vision

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family
- ☐ Waive Vision Coverage

Employee Supplemental Life w/ AD&D (x Salary)

☐1x ☐2x ☐3x ☐4x* ☐5x* ☐6x* ☐7x* ☐8x*

☐ Waive Supplemental Life Coverage

Spouse Life (Increments of $10,000 up to $500,000)

☐ Guaranteed up to $50,000: $_____

☐ Waive Spousal Life Coverage

Child(ren) Life (Increments of $5,000 up to $15,000)

☐ Enroll: $_____

☐ Waive Child(ren) Life Coverage

*You must complete medical questions if your election exceeds 3X salary or $500,000.

USG Voluntary AD&D

Employee Plan
(Increments of $10,000 up to $500,000)

☐ Enroll: $_____

Family Plan: Spouse 40% + Child(ren) 10%; Spouse only 50%;
Child only 15% (percentage amounts are of the employee AD&D amount)

Spouse

☐ Enroll: $_____

Child(ren)

☐ Enroll: $_____

Disability (MetLife)

Short-term Disability

☐ Enroll

☐ Waive STD Coverage

Long-term Disability

☐ Enroll

☐ Waive LTD Coverage

Lifestyle Benefits

- ☐ Option A
- ☐ Option B
- ☐ Option C
- ☐ Option D

☐ **GT Identity Theft**

☐ **USG Legal**

USG Accident

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

USG Hospital Indemnity

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

USG Critical Illness

☐ Enroll: $_____

Spouse

☐ Enroll: $_____

Flexible Spending Account (FSA)

Health Care FSA

☐ [3]Annual Contribution: $_____

☐ Waive Health Care FSA

Dependent Care FSA

☐ [3]Annual Contribution: $_____

☐ Waive Dependent Care FSA

Health Savings Account (HSA) & LP HSA

Must be enrolled in the HSA POS medical plan to participate in these savings accounts.

☐ [3]HSA Annual Contribution: $_____
(Not including GT matching contribution)

☐ LP FSA Annual Contribution: $_____

☐ Waive Health Care FSA

[3]Annual contribution is divided over remaining paychecks for the calendar year.

Employee Name: _____

2017 New Hire Benefits Enrollment

SSN: _____

Revised 02/07/2017

Dependent Information

Last Name	First Name	M.I.	SSN (required)	DOB	Gender	Medical	Dental	Vision	Supporting Documents	Tobacco User	BlueChoice HMO Physician ID #
						(select coverage with an X)					

Tobacco Surcharge

A tobacco user is defined as any employee who is currently using tobacco products. "Tobacco products" include but are not limited to cigarettes, cigars and chewing tobacco. This election can only be changed if you certify that you have stopped using tobacco products.

Check one: ☐ I am currently a tobacco user ☐ I am not a tobacco user _____ _____

Signature Date

Acknowledgment & Authorization of Benefits

I have read and understood the following statements with regard to my health, dental and vision plan elections.

1. Network physicians, dentists, other healthcare professionals, facilities and agencies are subject to change during the plan year. To find out if your healthcare providers participate in the network, please contact the insurance carrier directly.
2. I authorize the adjustment of my annual taxable salary based on my elections, with the pre-tax funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year unless I experience a qualified change in status and have submitted documentation of this change within 30 days of the event. I further understand this form must be signed and dated prior to my plan effective date to be eligible to participate this plan year. Any unused amounts remaining in my account at the end of the plan year will be forfeited. However, I will have 90 days after the end of the plan year or date of my termination to submit receipts for reimbursement for services received during the plan year or coverage period.
3. Any dependents I am enrolling meet the eligibility requirements described in the benefit enrollment materials and/or plan documents. I understand, I must furnish a copy of my marriage license, divorce decree, adoption papers, birth certificate, court order establishing guardianship and/or any additional documentation required. Making false statements about meeting the eligibility requirements, failing to notify the Institute of loss of eligibility within 30 days of such loss, or failing to provide documentation when requested will lead to de-enrollment of the family member(s) and possible appropriate legal action. In addition, employees may be subject to disciplinary action and will be responsible for any employer contributions to and any additional costs paid by the Institute.

   I authorize deductions, if appropriate, for my benefit choices based on the current rate and any future rate changes. Deductions will be taken on a pre-tax or post-tax basis according to the Georgia Tech, Section 125 form.

_____ _____

Signature Date