



2010 BENEFITS ENROLLMENT WORKSHEET

For the period of 01/01/2010 to 12/31/2010

You will be required to use your Kettering University User Name and Password to make your enrollment elections. Use this worksheet as your guide in selecting your benefits.

BENEFIT COVERAGE

Benefit Costs are shown on a Per Pay Basis

MEDICAL

OPTIONS	SINGLE	2 PERSON	FAMILY
HealthPlus - HSA <input type="checkbox"/>	\$38.68	\$75.66	\$80.54
Health Savings Account <input style="width: 80px; height: 20px; border: 1px solid black;" type="text"/> / 24 = <input style="width: 80px; height: 20px; border: 1px solid black;" type="text"/>	Cap of \$1,850/Single or \$3,750 for Two Person and Family coverage		
HealthPlus - Healthy Solutions - HMO <input type="checkbox"/>	\$72.16	\$155.13	\$184.73
Blue Care Network - Healthy Blue Living - HMO <input type="checkbox"/>	\$24.95	\$53.64	\$63.89
BC Community Blue – PPO <input type="checkbox"/>	\$144.92	\$384.54	\$470.25
BC Rider (Dependent(s) between ages of 19-25) <input type="checkbox"/>	\$145.95	\$291.90	
No Coverage (Opt-Out)** <input type="checkbox"/>	(\$40.35)		

(Evidence of other coverage required)

Provider	Group #	Contract #	Subscriber

DENTAL

OPTIONS	SINGLE	2 PERSON	FAMILY
Delta Dental PPO (Point of Service) <input type="checkbox"/>	\$7.69	\$11.54	\$15.38
No Coverage (Opt-Out)** <input type="checkbox"/>	(\$12.50)		

(Evidence of other coverage required)

Provider	Group #	Contract #	Subscriber

VISION

OPTIONS	SINGLE	2 PERSON	FAMILY
NVA – Vision <input type="checkbox"/> (National Vision Administrators)	\$0.00	\$1.64	\$5.90

There is not an Opt-Out payment to this benefit

REIMBURSEMENT ACCOUNTS

Health and Dependent Care Account deductions will begin with your first paycheck of the new calendar year and are taken from the first two (2) pays of each month. There is a \$5,000 maximum for each account.

Annual Amount / 24 = Per Pay Amount

Health Care Reimbursement	<input style="width: 80%; height: 20px; border: 1px solid black;" type="text"/>	/ 24 =	<input style="width: 80%; height: 20px; border: 1px solid black;" type="text"/>	***
(For out of pocket health expenses not covered by insurance)				
Dependent Care Reimbursement	<input style="width: 80%; height: 20px; border: 1px solid black;" type="text"/>	/ 24 =	<input style="width: 80%; height: 20px; border: 1px solid black;" type="text"/>	

**Opt-Out is paid over 26 pay periods with appropriate confirmation of other coverage.
 ***For those participating in the HealthPlus HSA, you may only use the HCRA for Dental and Vision expenses and limited medical expenses.

LEGAL SERVICES

Pre-Paid Legal	No Election	<input type="checkbox"/>	\$0.00	Election	<input type="checkbox"/>	\$ 7.48
Identity Theft Shield	No Election	<input type="checkbox"/>	\$0.00	Election	<input type="checkbox"/>	\$ 6.50
Pre-Paid Legal and Identity Theft Shield	No Election	<input type="checkbox"/>	\$0.00	Election	<input type="checkbox"/>	\$12.96

There is not an Opt-Out payment to this benefit

LIFE INSURANCE

Basic Life (Employer paid) 2 X Annual Base Salary
There is not an Opt-Out payment to this benefit

Additional Life Insurance (Employee paid) 1 X Annual Base Salary 2 X Annual Base Salary
 3 X Annual Base Salary 4 X Annual Base Salary
 5 X Annual Base Salary

The cost is calculated based on your salary and age.

Accidental Death & Dismemberment (AD&D) (Employer paid) 2 X Annual Base Salary
There is not an Opt-Out payment to this benefit

Additional AD&D (Employee paid) 1 X Annual Base Salary 2 X Annual Base Salary
 3 X Annual Base Salary 4 X Annual Base Salary
 5 X Annual Base Salary

The cost is calculated based on your salary.

Dependent Life Insurance \$10,000/\$2,000
 \$20,000/\$4,000
 \$30,000/\$6,000
 \$40,000/\$8,000
 \$50,000/\$10,000

Rates are calculated based on the Employee's age. Your election cannot exceed 100% of your additional life election.

YOUR DEPENDENTS					Place a checkmark in the Medical, Dental and Vision boxes below indicating your election for each listed dependent.		
Name	Social Security #	Date of Birth	Gender	Relationship	Medical	Dental	Vision

I have received and read my enrollment materials. I authorize Kettering University to make deductions from, or additions to, my pay based upon the options chosen through Kettering University.

Signature

Date