KING'S COLLEGE
TRANSFORMATION. COMMUNITY. HOLY CROSS.

FOR EMPLOYER USE

Qualifying Employee Event: ☐ New Hire ☐ Loss of Other Coverage ☐ Gain of Eligibility

Qualifying Dependent Event: ☐ Birth ☐ Marriage ☐ Loss of Other Coverage ☐ Support Order

Effective Date of Benefits: _____ Date of Hire: _____

EE Salary/Hourly Rate: _____ Job Title: _____

*Employer Signature: _____ Date: _____

*Upon signature, the employer indicates that this form has been reviewed and all information is accurate.

ENROLLMENT CHANGE FORM

Employee Information

Social Security Number	Last Name	First Name	MI

Address	City	State	Zip

Date of Birth	Gender	Marital Status	Phone Number	Email
	☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced		

Plan Elections

	Employee Only	EE + Child	EE + Children	EE + Spouse	Family	Waiver*
Medical Plans (bi-weekly deductions)						
Value Plan $500	☐ $62.23	☐ $155.04	☐ $155.04	☐ $182.33	☐ $220.54	
Core Plan $750	☐ $93.89	☐ $232.55	☐ $232.55	☐ $262.03	☐ $328.63	☐
Premier Plan $300	☐ $125.56	☐ $279.50	☐ $279.50	☐ $326.45	☐ $412.70	

*Reason for Waiving Medical Coverage: _____

I hereby certify that I and my eligible dependents have been given the opportunity to participate in the group health insurance plan offered by my employer. I understand that in the event that I decide to apply for this coverage at a later date not related to a lifestyle change I and any eligible dependents will have to wait until the annual open enrollment period for enrollment. I understand I may be required to provide proof of other coverage.

Telemedicine Plan						
Revive Health	Enrollment is automatic when enrolling in a medical plan.					
Dental Plan (bi-weekly deductions)						
Delta Dental Plan	☐ $10.51	☐ $19.05	☐ $27.86	☐ $19.05	☐ $27.86	☐
Vision Plan (bi-weekly deductions)						
VBA Vision Plan	☐ $1.57	☐ $4.38	☐ $4.38	☐ $4.38	☐ $4.38	☐

Dependent Information

	Name (Last/First/MI)	Gender	Date of Birth	Social Security Number	Medical	Dental	Vision
Spouse		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Dependent		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Dependent		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Dependent		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive
Dependent		☐ M ☐ F			☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive

Please check next page to ensure this form is completed in its entirety.

Spending Accounts Options

	Per Pay Contribution	Annual Contribution
Flexible Spending Account (FSA)	**$**	**$** Up to $3,050
Dependent Care Account (DCA)	**$**	**$** Up to $5,000

Employer Paid Benefits & Voluntary Life Insurance

You are automatically enrolled in the following:			
☒ Long Term Disability	☒ Life Insurance	☐ Voluntary Life Insurance*	☐ I do not wish to elect Voluntary Life Insurance at this time.

*Voluntary Life Insurance is in addition to the company paid benefit.
*If electing Voluntary Life you must complete a **Guardian Application** and may be required to complete an evidence of insurability form.

Voluntary Worksite Benefits

Colonial Voluntary Benefits

The following voluntary benefits are offered through Colonial: Critical Illness Insurance, Accident Insurance, and Cancer Insurance. If you would like to enroll in voluntary benefits offered through Colonial Life, please **contact Bob Roth at bob.roth@colonialdemd.com or call him at (302) 235-3088 ext. 5.**

Beneficiary Information

Beneficiary for Death Benefits — *Right to change beneficiary is reserved to the insured.*

If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information. If additional space is needed, please attach a separate page, signed, and dated.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
					100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
					100%

Employee Signature

Please note that all deductions will be taken on a pre-tax basis unless otherwise instructed. I understand that I cannot change or revoke my election as of any date prior to the next open enrollment period unless I notify my Human Resources office within 30 days of a qualified change in status. The information provided above is true and correct to the best of my knowledge and I accept the provisions that I have read and understood.

Employee Signature _____ Date _____

Creative Benefits, Inc.
strategies to insure your success

Ellis Preserve Office | 3809 West Chester Pike, Suite 190 | Newtown Square, PA 19073
Kingston Office | 31 North Gates Avenue | Kingston, PA 18704

If you have any questions about completing this form, please call Creative Benefits, Inc.'s ESR team or your HR Department.
ESR Team: 1-844-231-8414 | esr@creativebenefitsinc.com

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