Instructions for completing the Benefits Enrollment/Change Form

1. **COMPLETE every section of the form – If you don't plan to enroll in any of the plans, please check the waive box.**

2. **If you add any dependents to your coverage, you must provide appropriate documentation to the benefits team. Please refer to the following link: http://mybenefits.trinity-health.org/trinity-health-dependent-verification for appropriate documentation. If documentation is not provided within the specified timeframe, dependents will be removed from coverage.**

3. **Return the completed forms and supporting documentation within the specified timeline to:**
   Human Resources:
   Sisters of Providence – Ann Ferguson
   Genesis & Providence Ministries - Cindy Lees

4. **If you have any questions, you may contact a member of the benefits team by calling:**
   (413-420-2555 Ann Ferguson or Cindy Lees (Genesis- 562-3627, Providence Ministries - 536-9109)

PLEASE NOTE:
ANY INFORMATION YOU HAVE RECEIVED REGARDING HR4U DOES NOT APPLY TO US
THAT IS FOR TRINITY HEALTH EMPLOYEES ONLY

Trinity Health Of New England

BENEFIT OPEN ENROLLMENT FORM 2022

COLLEAGUE INFORMATION		
Colleague Name (Last, First MI)	Date of Birth (MM/DD/YYYY)	Colleague ID Number
Street Address	Social Security Number _____-_____-_____	Marital Status ☐ Single ☐ Married ☐ Divorced
City, State, Zip	Telephone	**EFFECTIVE:**

MEDICAL INSURANCE - AETNA						
Type of Coverage:	☐ Traditional PPO	☐ Health Savings PPO	☐ Essential PPO	☐ Waive		
Action Needed:	☐ New Enrollment	☐ Add Dependent	☐Remove Dependent			
Level of Coverage:	☐ Colleague Only	☐EE + 1	☐ EE + Child(ren)	☐Family	☐EE + LDA	☐Family W/LDA

LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS TO BE ENROLLED UNDER YOUR MEDICAL COVERAGE
(If removing a dependent, please list the dependent you are removing from coverage ONLY)

Members	Name (Last, First)	SSN	Date of Birth MM/DD/YYYY	Gender M/F
Colleague				
Spouse/LDA*				
Child*				
Child*				
Child*				

***Proof of relationship will be required**

HEALTH SAVINGS ACCOUNT W/ HEALTH EQUITY– Only For Health Savings PPO (2022 IRS Limits: $3,650 Individual / $7,300 Family; additional $1,000 if over age 55) Trinity Health of New England Annual Contribution: $650 Individual/ $1,300 Family.		
Health Savings Account	☐ Enroll / Annual Contribution Amount $_____ ☐ Change / Annual Contribution Amount $_____	☐ Waive ☐ Terminate

FLEXIBLE SPENDING ACCOUNT – WAGE WORKS (2022 IRS Limits: Min: $130 Max:$2,750 Health Care FSA / $5,000 Dependent Care		
Healthcare FSA (Only if not enrolled in Health Savings PPO)	☐ Enroll / Annual Contribution Amount $_____ ☐ Change / Annual Contribution Amount $_____	☐ Waive ☐ Terminate
Dependent Care FSA	☐ Enroll / Annual Contribution Amount $_____ ☐ Change / Annual Contribution Amount $_____	☐ Waive ☐ Terminate

DENTAL INSURANCE – DELTA DENTAL of MICHIGAN						
Type of Coverage:	☐ High Plan	☐ Standard Plan	☐ Waive			
Action Needed:	☐ New Enrollment	☐ Add Dependent	☐Remove Dependent			
Level of Coverage:	☐ Colleague Only	☐ EE+ 1	☐ EE + Child(ren)	☐ Family	☐ EE + LDA	☐Family w/ LDA

Colleague ID _____

LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS TO BE ENROLLED UNDER YOUR DENTAL COVERAGE
(If removing a dependent, please list the dependent you are removing from coverage ONLY)

Members	Name (Last, First)	SSN	Date of Birth MM/DD/YYYY	Gender M/F
Colleague				
Spouse/LDA*				
Child*				
Child*				
Child*				

*** Proof of relationship will be required**

VISION INSURANCE – UNITED HEALTHCARE (PRE-TAX/COLLEAGUE PAID)				
Type of Coverage:	☐ High Plan	☐ Standard Plan	☐ Waive	
Action Needed:	☐ New Enrollment	☐ Add Dependent	☐Remove Dependent	
Level of Coverage:	☐Colleague Only	☐ EE + 1	☐EE + Child(ren)	☐Family

LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS TO BE ENROLLED UNDER YOUR COVERAGE
(If removing a dependent, please list the dependent you are removing from coverage ONLY)

Members	Name (Last, First)	SSN	Date of Birth MM/DD/YYYY	Gender M/F
Colleague				
Spouse/LDA*				
Child*				
Child*				
Child*				

*** Proof of relationship will be required**

EMPLOYER PAID GROUP LIFE INSURANCE – THE HARTFORD

This benefit is an Employer paid benefit. Please designate your beneficiary. Remember that the total percentage for both Primary AND/OR Contingent must equal 100%

Primary Beneficiary:

Name (Last, First MI)	Relationship to colleague and date of birth	Percentage
Street Address City, State, Zip	Social Security Number _____--_____--_____	

☐ Primary OR ☐ Contingent Beneficiary

Name (Last, First MI)	Relationship to colleague and date of birth	Percentage
Street Address City, State, Zip	Social Security Number _____--_____--_____	

☐ Primary OR ☐ Contingent Beneficiary

Name (Last, First MI)	Relationship to colleague and date of birth	Percentage
Street Address City, State, Zip	Social Security Number _____--_____--_____	

Use another sheet if you need to add additional beneficiaries.

Colleague ID _____

SUPPLEMENTAL LIFE INSURANCE (POST-TAX/COLLEAGUE PAID)- THE HARTFORD If you plan to enroll in any amount over the Guaranteed Issue amount, Personal Health Application will be required	
COLLEAGUE **Guaranteed Issue: 3x Salary or $1M**	☐ 1x ☐ 2x ☐ 3X ☐ 4X ☐ 5x ☐ 6x ☐ 7X ☐ 8X ☐ Waive
SPOUSE **Guaranteed Issue: 20K**	☐ 10K ☐ 20K ☐ 50K ☐ 80K ☐ 100K ☐ Waive
CHILD **Guaranteed Issue: 20K**	☐ 5K ☐ 10K ☐ 20K ☐ Waive

*__If electing Colleague Supplemental Life Insurance – your beneficiaries must match the beneficiaries designated for your Group Term Life Insurance.__

SUPPLEMENTAL AD&D (POST-TAX/COLLEAGUE PAID)- THE HARTFORD	
COLLEAGUE	☐ 1x ☐ 2x ☐ 3X ☐ 4X ☐ 5x ☐ 6x ☐ 7X ☐ 8X ☐ Waive

PTO CASH OUT ELECTION	
PTO Election	Elect the amount of PTO hours to be paid out in first pay-check in November, 2022 You may elect 8 to 80 hours _____ You must leave a balance of 40 hours in your bank at time of payout in 2022.

IMPORTANT: COLLEAGUE/MEMBER CONSENT

- I hereby apply for the health plan and benefit plan selected above, understanding all benefits and coverage as specified in the enrollment materials and agree to abide by all the rules and regulations therein specified.
- I understand that in order to enroll a dependent under my plan(s) elected, I am required to provide verification of dependent status. I am to refer to the Dependent Eligibility Requirements document for a complete listing of eligibility documentation required.
- I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage.
- I confirm that the information provided is true and correct to the best of my knowledge. I understand that misstatements, misrepresentations, or omissions may result in the cancellation of insurance coverage.

Colleague Signature: _____Date:_____

Please Note:
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 30 days.