

Hamilton College Benefits Selection Form
Effective January 1, 2010

Name: _____
(please print)

COMPLETE THIS FORM ONLY IF YOU ARE REQUESTING A CHANGE TO YOUR CURRENT HEALTH, DENTAL AND/OR VISION ELECTION. I elect the following change(s) to my benefit enrollments for 2010:

A. Health Insurance:

Change my current health insurance election to:

_____ MVP Preferred PPO
 ___ Employee
 ___ Employee +1
 ___ Family

_____ MVP HMO/POS
 ___ Employee
 ___ Employee +1
 ___ Family

_____ Waive Coverage. Waiver payment will apply. (Attach proof of other coverage.)

Note: If you are a new enrollee or you are adding covered dependents, please complete an MVP enrollment form. If you are changing from the Preferred PPO to the HMO/POS plan, please complete an MVP enrollment form listing a primary physician for each covered person.

B. Dental Coverage (with First Ameritas):

_____ Enroll for Coverage (complete Dental/Vision Enrollment Form)
 ___ Employee
 ___ Employee +1
 ___ Family

_____ Change Coverage (if you are adding dependents, complete Dental/Vision Enrollment Form)
 ___ Employee
 ___ Employee +1
 ___ Family

_____ Cancel coverage

C. Vision Coverage (with VSP):

_____ Enroll for Coverage (complete Dental/Vision Enrollment Form)
 ___ Employee
 ___ Employee +1
 ___ Family

_____ Change Coverage (if you are adding dependents, complete Dental/Vision Enrollment Form)
 ___ Employee
 ___ Employee +1
 ___ Family

_____ Cancel coverage

Signature _____

Date _____