

Hamilton College Benefits Selection Form
Effective January 1, 2012

Name: _____
(please print)

COMPLETE THIS FORM ONLY IF YOU ARE REQUESTING A CHANGE TO YOUR CURRENT MEDICAL, DENTAL AND/OR VISION ELECTION. I elect the following change(s) to my benefit enrollments for 2012:

Medical Insurance:

Change my current medical insurance election to:

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

_____ MVP 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 POS plan, please complete an MVP enrollment form listing a primary physician for each covered person.

Dental Coverage (with 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

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 _____