DELTA COLLEGE BENEFITS ENROLLMENT FORM
PLAN YEAR: 2026

Section A - Employee Information

Employee Name:	Social Security No:
Address:	City/State/Zip:
Email Address:	Employee ID#:

Phone: Sex: Date of Hire: Date of Birth:

Section B – Select Action (circle one)

Effective Date of Qualifying Event:

Open Enrollment	New Hire/Full-time Position	Resignation/Retirement

Birth of Child	Marriage	Divorce	Other:

Qualifying events must be communicated within 30 days to Human Resources. Failure to notify Human Resources within 30 days may cause the employee to be liable for insurance claims and college paid health, vision and dental premiums. Documentation is required for qualifying events to be processed. (Additions - marriage licenses and birth certificates. Removal - divorce decree)

Section C – Benefit Elections

Dental Insurance (circle election below)

1. College-paid dental insurance	Single	2 Person	Family

Health/Vision Insurance (circle election below)

1. DECLINE health insurance but receive College-paid vision	Single	2 Person	Family
2. PPO Plan and College-paid vision insurance	Single	2 Person	Family
20% cost share of premium	$175 / month	$420 / month	$525 / month
3. High Deductible Health Plan with Health Savings Account and College-paid vision insurance	Single	2 Person	Family
20% cost share of premium	$124 / month	$298 / month	$372 / month
HSA Additional Employee Contribution Single ($4,400 max) 2P/Family ($8,750 max)	$ / pay	$ / pay	$ / pay

Flexible Spending Accounts–Minimum contribution amount for the calendar year is $250 for health and/or dependent care.

Cannot participate if you & your spouse have an HSA.	Health Care maximum $3,200 annually	$	Annual Amount
	Dependent Care maximum $7,500 annually	$	Annual Amount

Section D – Dependent Information

Name (First, MI, Last)	Social Security #	Birth Date	M/F	Check One Add	Remove
Spouse					
Dep. 1					
Dep. 2					
Dep. 3					
Dep. 4					

COBRA NOTIFICATION ADDRESS: _____

Complete only if you are discontinuing coverage for a covered member

Section E - Authorization

I acknowledge that:

- I have reviewed Delta College's benefit plan documents for which I am enrolling.
- By signing this form, I make a binding election concerning my benefits for the plan year of January 1 – December 31, 2026.
- I understand that I will not be able to change my elections unless I have a qualifying event. (marriage, divorce, death, birth or adoption of a child, termination of employment of a spouse, or other such qualifying events allowed by the plans)
- I authorize Delta College to reduce my annual salary in accordance with my elections.
- Eligible deductions will be taken on a pre-tax basis and my social security benefits may be reduced.
- Delta College may reduce or cancel my compensation reduction or otherwise modify this agreement in the event that it is advisable in order to satisfy certain provisions of the IRS.
- I will be offered the opportunity to change my benefit elections for the following plan year during open enrollment.
- If I do not complete and return a new election form during open enrollment, these elections will remain in place for future plan years except for Flexible Spending.
- Any Flex Spending payroll contribution not collected must be paid to Delta College within 30 days of the payroll date it was due. Failure to pay within this timeframe will terminate participation in the Flex Spending Plan for the remainder of the year.
- The Flex Spending debit card is to be used exclusively for qualified expenses incurred during the Plan Year. If used for an unqualified expense or if substantiation is not provided, I authorize Delta College to take an after-tax deduction from my paycheck to cover the expense.
- I understand that I could forfeit Flex Spending Plan contributions if I fail to incur eligible expenses during the Plan Year or fail to submit payment requests with in the timeframe specified by the Plan Document.
- Employees on a sick or FMLA leave continue to be responsible for paying their share of premiums for benefit plans. If the employee fails to pay their share of the premiums, the coverage will be terminated with prior notice.
- The primary insured/HSA account holder cannot have dual coverage. Each spouse must open a separate HSA.
- I affirm that the information provided is correct. I understand that if I submit false information, I may be held financially responsible for all claims filed and be required to reimburse the College for any payments made on behalf of or for the benefit of an ineligible dependent.

Employee Signature: _____ Date: _____

HUMAN RESOURCES OFFICE USE ONLY

Transfer		Benefit	Benefit Effective/Separation Date	Colleague Processed	
From:		PPO / HDHP-HSA			COBRA
To:		Dental			PREL / PBEN
		Vision			1095C
POSS Class:		Flexible Spending	BCBS ck mark Next day – BCBS CDH		Newsletter?
		HSA	BCBS ck mark Email Payroll	EHSA HDHP excel	Rec 2nd Pay?