

Harvard Pilgrim Open Enrollment On-Line Instructions

You will be enrolling in Harvard Pilgrim online. It is easier and faster than paperwork! Just follow the instructions below and when you are finished, your employer will review the information and submit it Harvard Pilgrim.

- Go to www.harvardpilgrim.org and select **Member Login**
- Scroll down and click on **Enroll in Harvard Pilgrim**
- Welcome to the New Enrollment screen. You will be asked to enter your **Employer ID which is 0000062318**
- Your Effective Date is **07/01/2021**
- Reason for Enrollment is **OPEN ENROLLMENT**
- Select Plan Options
- Enter Member Information
- Review your information and then click submit
- Print Thank you Page and retain your tracking number for your records

If you have any questions regarding HPConnect, you may call 1-800-676-2769 Monday – Friday from 8:00 AM to 5:30 PM

To conclude your enrollment the District requires anyone enrolling a spouse in a family plan to submit a copy of your marriage certificate to the HR Office.

A section 125 plan enrollment form is attached to this document. Any employee enrolling in health insurance will need to fill out this form, sign, date and return to the HR Office. This form allows us to take the premium for your health insurance from your paycheck pre-taxed.

If you have any questions regarding your enrollment, please call Carolyn Collins at 508-520-7991 ext. 2315 or email collinsc@kingphilip.org

King Philip Regional School District

Flexible Benefits Plan: Enrollment Form

Employee Name: _____ Telephone: (_____) _____

Employee Address: _____

City: _____ State: _____ Zip: _____

Employee Social Security Number: _____ - _____ - _____ Plan Year: _____ through _____

Date of Birth: _____ / _____ / _____ Hire Date: _____ / _____ / _____ Effective Date: _____ / _____ / _____

The District and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement). I understand that if I **do not** return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan and therefore cause me to pay insurance premiums with after-tax dollars.

Employee's Flexible Benefits Per Pay Deduction/Allocation

Medical	per pay contribution \$ _____	date of 1 st payroll _____
Basic Life Insurance	per pay contribution \$ _____	date of 1 st payroll _____
Supplemental Life	per pay contribution \$ _____	date of 1 st payroll _____
Dental	per pay contribution \$ _____	date of 1 st payroll _____
Vision	per pay contribution \$ _____	date of 1 st payroll _____

I understand that:

- (1) If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirected will automatically be adjusted to reflect that increase or decrease.
- (2) Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my pre-tax premium benefit coverage then in effect for the new plan year. In addition, this compensation redirection agreement will continue by its terms in the amount of the required contribution for the benefit option for premiums only.
- (3) I cannot change or revoke this taxable compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination, or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- (4) The Plan Administrator may reduce or cancel my taxable compensation redirection or otherwise modify this agreement in the event he/she believes it is advisable to satisfy certain provisions of the Internal Revenue Code.

This agreement is subject to the terms of the District's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior election and Taxable Compensation Redirection Agreement relating to such plan(s). By signing this form, I agree to the terms and procedures listed herein.

I acknowledge that I have been given the opportunity to participate in the Benefits offered by my employer under the Flex Program and I have decided **not** to participate at this time.

Employee Signature: _____

Date: _____

Please return this form to Carolyn Collins ~ HR Office