

**Brigham and Women's Hospital (BWH)
Benefits Enrollment and Change Worksheet**

Please read your enrollment materials for details on your benefits options before you complete this worksheet. Then, use this worksheet to select the benefits options you want and guide you while you enroll in/change your benefits online using PeopleSoft eBenefits. Access eBenefits through Employee Self Service (ESS) on the Internet at: <http://ibridge.partners.org>

You can access eBenefits from any computer that has an Internet connection, or use computer terminals with eBenefits access at these locations: BWH Human Resources Office, 801 Mass. Ave. 7th Floor, Boston (3 terminals are available), 7th Floor, Boston; Partners Benefits Office, 101 Merrimac Street, 5th Floor, Boston (5 terminals are available).

If you have questions about this form, please contact the Partners Benefits Office at (617) 726-8133 or via email at ibenefits@partners.org. If you are unable to make your elections online, please mail your form to Benefits Office, Partners HealthCare, 101 Merrimac St., 5th Floor, Boston, MA 02114, or fax it to (617) 726-8428.

Date of Status Change: _____

Last Name: _____ First Name _____ Employee ID: _____

Date of Birth: _____ Phone Number: _____

The IRS allows you to change your pre-tax benefits during the year within 30 days of the date you experience a qualified change of status. Also, your benefit change must be consistent with your status change. Your pre-tax benefits include medical, dental, health and dependent care accounts.

Check the box that describes the change of status you have experienced in the last 30 days:

- Marriage or divorce
- Addition of a dependent through birth, adoption or change in custody
- Death of spouse or dependent
- Gain or loss of eligibility for Medicaid, Medicare or other group coverage. For other group coverage, list employer name and phone number: _____
- Your spouse has changed from benefits-eligible to benefits-ineligible status, or vice versa
- Your spouse's employment has ended
- You have moved out of your HMO's service area
- Gain or loss of full-time student status for dependent age 19 to age 26 (you must also submit an *Over-Age Dependent Verification Form*, available on the Benefits website.)
- Leave of Absence (Due to significant rate increase, please contact your Leave Coordinator or the Benefits Office.)

Comments: _____

DEPENDENT INFORMATION

Use the following to enroll your eligible dependents, your Same-Sex Spouse or your Same-Sex Domestic Partner in Flex Benefits.

Legal Spouse

Last Name	First Name	Date of Birth	Sex (M/F)	SSN
_____	_____	_____	_____	_____

Same Sex Domestic Partner (SSDP) or Same Sex Spouse (SSSp)

Last Name	First Name	Date of Birth	Sex (M/F)	SSN
_____	_____	_____	_____	_____

Dependent Child(ren)

Last Name	First Name	Date of Birth	Sex (M/F)	SSN	Full-Time Student 19 or older*	Child of SSDP/SSSp (not employee)**	Disabled and 19 or older***
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Dependent Child(ren) age 19 to age 26.
 ** Child(ren) must be legal dependent of your partner
 *** Must be approved by carrier.