Change in Family Status Form

(Fill out only to request a Change in Participation during the year.)

Employer: ________________________________

Full Name: ________________________________

SSN: ________________________________

- **Check the appropriate box** to indicate a Change in Family Status. One or more of the events listed below qualifies you to change your Redirected Amounts or your participation in the FSA during the Plan Year. Changes cannot be retroactive and must be consistent with the events indicated.

- **Change In Martial Status**………………………………………………
  - ☐ Marriage
  - ☐ Divorce
  - ☐ Legal Separation

  * Date of Event_________

- **Change In Dependent Status**…………………………………………..
  - ☐ Birth
  - ☐ Adoption
  - ☐ Death
  - ☐ Loss of Dependent

  * Date of Event_________

- **Change In Work Status**………………………………………………

	YOU	**YOUR SPOUSE**
Termination of Employment……………………………	☐	☐
Commencement of Employment..………………………	☐	☐
Part-time to Full-Time…………………………………..	☐	☐
Full-time to Part-Time…………………………………..	☐	☐
Other ____________________………………	☐	☐

  * Date of Event_________

- **Other Change In Family Status (Explain in Detail)**

  * Date of Event_________

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____

-Documentation verifying all changes listed above may be required.-

I understand that I may be required to provide the appropriate documentation for any of the changes in family status that I have checked above. The family status and participation changes will be reviewed. If my change in participation is denied, I will have 60 days to appeal the decision. If again denied, I may pursue other rights accorded to me under ERISA.

I HEREBY ELECT THE PARTICIPATION CHANGE(S) NOTED ON THE REDIRECTION FORM ATTACHED AND ATTEST THAT THE CHANGE(S) IS CAUSED BY AND CONSISTENT WITH THE CHANGE(S) IN FAMILY STATUS.

Employee

____
Signature

Date: ______________________________

Accepted and agreed to
By: ______________________________
Plan Administrator/Employer

Date: ______________________________

Enrollment/Change Form

☐ Newly Eligible Associate
☐ Mid Plan Year Change - Qualified Change in Family Status Form attached

Effective Date of Coverage: ____________________

Department Number: ____________________

ASSOCIATE INFORMATION (PLEASE PRINT)

Last Name	First Name	M.I.	Social Security Number - -
Home Address	City	State	Zip / Home Phone Number ( ) -
Email	Hire/Eligible Date MM/DD/YYYY / /	Birth date MM/DD/YYYY / /	Job Title
Gender ☐ Male ☐ Female / Marital Status ☐Married ☐ Single	Marriage Date MM/DD/YYYY / /	Spouses Name (Last, First)	Spouses Birthdate MM/DD/YYYY / /

Do you or any of your covered dependents have other health insurance covera ☐ *Yes* ☐ *No* — If yes, Complete **OTHER INSURANCE** Section below:

Are you, your spouse, or any dependents eligible for Medicare? ☐ *Yes* ☐ *No* — If yes, which persons?

MEDICAL-RX/DENTAL/VISION ELECTIONS (elect the plan(s) and who will be enrolled) ⊇ Traditional Plan, ⊇ Wellness Plan, ⊇ Waive

DEPENDENT(S)' CHANGE IN STATUS

Please list those legal dependents who are enrolling or changing their insurance status.

Medical	Dental	Vision	RELATIONSHIP	Add	Delete	Change	LAST NAME, FIRST NAME, M.I.			BIRTHDATE	SOCIAL SEC. NUMBER	GENDER
☐	☐	☐	Associate	☐	☐	☐				___ / ___ / ___	_______-____ -_______	M / F
☐	☐	☐	Spouse	☐	☐	☐				___ / ___ / ___	_______-____ -_______	M / F
☐	☐	☐	Child	☐	☐	☐				___ / ___ / ___	_______-____ -_______	M / F
☐	☐	☐	Child	☐	☐	☐				___ / ___ / ___	_______-____ -_______	M / F
☐	☐	☐	Child	☐	☐	☐				___ / ___ / ___	_______-____ -_______	M / F
☐	☐	☐	Child	☐	☐	☐				___ / ___ / ___	_______-____ -_______	M / F

☐ I DECLINE the following plan(s) marked___ Medical-RX, ___ Dental,___ Vision Insurance through Lourdes. I have other coverage or I have chosen to have no insurance at this time and will provide a completed waiver form. I understand that my next opportunity to elect coverage for myself or my dependents will be at next year's open enrollment, unless I have a family / work status change.

OTHER INSURANCE In order to properly process claims for your covered dependents, we need information in regard to any other health plan under which they may be covered. Please answer the following questions:

Name of Spouse's Employer______________________________
Address of Employer________________________________
Phone Number of Employer_____________________________
If divorced, is there a court order for children's coverage? _______
If no Court Order, with whom do the children reside_____________

Are any benefits available from:	Employee	Spouse	Children
A. Any other group health plan?	Yes No	Yes No	Yes No
B. Any other dental plan?	Yes No	Yes No	Yes No
C. HMO?	Yes No	Yes No	Yes No
D. Prescription drug plan?	Yes No	Yes No	Yes No

Dependents covered___________________________________
Name of other insurance company________________________
Name of Employee____________________________________
Name of other employer_________________________________
Effective Date: ____________ Termination Date: ___________

VOLUNTARY LONG-TERM DISABILITY INSURANCE

I want to elect to PURCHASE Voluntary Long-Term Disability Insurance. ☐ 90 Day Elimination Period ☐ I wish to have 70% Up Grade Plan ☐ 180 Day Elimination Period	☐ I want to DECLINE or cancel the purchase of Voluntary Long-Term Disability Insurance. I understand that future elections may require Evidence of Insurability or contain pre-existing condition exclusions.	For Payroll Purposes Only Amount Deducted from Paycheck Based on Current Salary: $__________

AFLAC SUPPLEMENTAL INSURANCE

☐ I have decided to meet with the Aflac Supplemental Insurance representative. Please ask the representative to setup a meeting with me. I understand I am eligible for pre-tax benefits on the first of the month following 90 days of employment.	☐ I choose at

LEGAL PLAN

I want to elect to PURCHASE the Legal Plan. ☐ Employee Plan ☐ Family Plan	☐ I choose at this time to DECLINE or CANCEL the Legal Plan. I understand I have been given the option to purchase the Legal Plan.

SUPPLEMENTAL LIFE INSURANCE

I want to elect to PURCHASE Supplemental Life Insurance. ☐ COMPLETE SEPARATE ENROLLMENT FORM	☐ I choose at this time to DECLINE OR CANCEL the Supplemental Life Insurance for myself, my spouse, and children. I understand I have been given the option to purchase Supplemental Life Ins. and that future elections may require Evidence of Insurability.

YOUR AUTHORIZATION

I hereby make application for the benefit plans for which I am eligible. I certify that the benefits of these plans have been thoroughly explained to me. I authorize payroll deductions of required contributions, if any. I understand that subject to Federal and State income tax laws, the health and dental deductions and contributions to the reimbursement accounts will be made before taxes. I understand that I cannot change the health, dental or vision elections or add or deletedependent health or dental coverage during the plan year unless I have a qualifying change in family status.
I also certify that the dependents listed are eligible for dependent Health and Dental coverage .

Associate Signature	Date