



Lourdes Health Network

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
- **Change In Dependent Status**..... Birth
 Adoption
 Death
 Loss of Dependent
- **Change In Work Status**..... **YOU** **YOUR SPOUSE**

Termination of Employment.....	<input type="checkbox"/>	<input type="checkbox"/>
Commencement of Employment.....	<input type="checkbox"/>	<input type="checkbox"/>
Part-time to Full-Time.....	<input type="checkbox"/>	<input type="checkbox"/>
Full-time to Part-Time.....	<input type="checkbox"/>	<input type="checkbox"/>
Other _____.....	<input type="checkbox"/>	<input type="checkbox"/>
- **Other Change In Family Status (Explain in Detail)**

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

- **Fill Out A Redirection Form** (A-14131-4-90 or M0019) to indicate the change(s) you wish to make in your Total Annual Redirected Amounts or in your participation. Changes you may make include, but are not limited to , increasing or decreasing the deduction amounts for medical/dental, and /or dependent care accounts, or withdrawing from participation.

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

Accepted and agreed to
 By: _____
 Plan Administrator/Employer

Date: _____

Date: _____

REASON FOR ENROLLMENT OR CHANGE

- New Associate-Standard Eligibility:
Effective Date _____
- Open Enrollment. **Effective January 1st.**
- Associate Family/Work Status Change
- Marriage
- Birth
- Adoption
- Involuntary loss of coverage: Date of loss _____
(attach verification of previous coverage)
- DSHS Requirement
- Other _____
- Family/Work Status Change Date Is: ___/___/___
- Divorce (attach Divorce Decree)
- Death (attach Death Certificate)
- Dependent change
(i.e., over age, change to other coverage, etc.)
- Reduction of hours

Change of Information

(check all that apply)

- Name
- Beneficiary (see box below)
- Address (for Benefits purposes only)
- Add/delete (circle one) dependent from: _____
- Add/delete (circle one) self from: _____
- Long Term Disability only
- Voluntary Term Life only
(HR use only)

Sent to Loomis Delta VSP

ASSOCIATE INFORMATION (PLEASE PRINT)

Last Name		First Name		M.I.	Social Security Number	
Home Address			City	State	Zip	Home Phone Number () -
Employee Number	Hire Date MM/DD/YYYY	Birth date MM/DD/YYYY	Job Title			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> 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 coverage? 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Associate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		___/___/___	___-___-___	M / F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		___/___/___	___-___-___	M / F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		___/___/___	___-___-___	M / F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		___/___/___	___-___-___	M / F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		___/___/___	___-___-___	M / F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		___/___/___	___-___-___	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.

For Payroll Purposes Only

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 _____	Are any benefits available from:	Employee	Spouse	Children	Dependents covered
Address of Employer _____	A. Any other group health plan?	Yes No	Yes No	Yes No	Name of other insurance company _____
Phone Number of Employer _____	B. Any other dental plan?	Yes No	Yes No	Yes No	Name of Employee _____
If divorced, is there a court order for children's coverage? _____	C. HMO?	Yes No	Yes No	Yes No	Name of other employer _____
If no Court Order, with whom do the children reside _____	D. Prescription drug plan?	Yes No	Yes No	Yes No	Effective Date: _____ Termination Date: _____

VOLUNTARY LONG-TERM DISABILITY INSURANCE

<input type="checkbox"/> I want to elect to PURCHASE Voluntary Long-Term Disability Insurance.	<input type="checkbox"/> I want to DECLINE or cancel the purchase of Voluntary Long-Term Disability Insurance. I understand that if I wish to purchase this coverage at a later date, I will be required to supply proof of good health at my own expense.	For Payroll Purposes Only Amount Deducted from Paycheck Based on Current Salary: \$ _____
<input type="checkbox"/> 90 Day Elimination Period <input type="checkbox"/> I also wish to have 70% Up Grade Plan		
<input type="checkbox"/> 180 Day Elimination Period		

SUPPLEMENTAL INSURANCE

<input type="checkbox"/> I have decided to meet with the 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.	<input type="checkbox"/> I choose at this time to waive the Supplemental Insurance. I understand I have been given the option to purchase Supplemental Insurance.
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LEGAL PLAN

<input type="checkbox"/> I want to elect to PURCHASE the Legal Plan. <input type="checkbox"/> Employee Plan <input type="checkbox"/> Family Plan	<input type="checkbox"/> I choose at this time to waive the Legal Plan. I understand I have been given the option to purchase the Legal Plan.
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VOLUNTARY TERM LIFE INSURANCE

<input type="checkbox"/> I want to elect to PURCHASE Voluntary Term Life Insurance for: <input type="checkbox"/> Associate supplemental - based on Annual Salary <input type="checkbox"/> 1x's <input type="checkbox"/> 2x's <input type="checkbox"/> 3x's <input type="checkbox"/> 4x's <input type="checkbox"/> 5x's = \$ _____ (check evidence of good health requirements)	For Payroll Purposes Only
<input type="checkbox"/> Spouse - How many units <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 (check evidence of good health requirements)	
<input type="checkbox"/> Child(ren) - <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 or <input type="checkbox"/> \$10,000	
<input type="checkbox"/> I want to DECLINE or cancel the purchase of Voluntary Term Life Insurance. I understand that if I wish to purchase this coverage at a later date, I will be required to supply proof of good health at my own expense.	
<input type="checkbox"/> I want to REDUCE my Voluntary Term Life Insurance. Indicate new total amount: \$ _____	Amount Deducted from Paycheck
<input type="checkbox"/> I want to INCREASE my Voluntary Term Life Insurance. Indicate new total amount: \$ _____	\$ _____

Life/AD&D Beneficiary Designation

Beneficiary Name	Relationship	<input type="checkbox"/> Primary
Beneficiary Address	City State Zip	<input type="checkbox"/> Contingent %
Beneficiary Name	Relationship	<input type="checkbox"/> Primary
Beneficiary Address	City State Zip	<input type="checkbox"/> Contingent %
Beneficiary Name	Relationship	<input type="checkbox"/> Primary
Beneficiary Address	City State Zip	<input type="checkbox"/> Contingent %
Beneficiary Name	Relationship	<input type="checkbox"/> Primary
Beneficiary Address	City State Zip	<input type="checkbox"/> Contingent %

For Life Insurance and Voluntary Personal Accident Insurance in the event of your death. If more than one beneficiary is named, unless otherwise noted here, benefits will be provided in equal shares.

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 delete dependent 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
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