BENELECT 2024 CHANGE OF STATUS FORM

You have **30 days after your change** of status to notify Benefits Administration and change your Benelect choices. As noted in your Benelect Guide, the benefit choices you make are in effect for one calendar year and may be changed only during the annual enrollment period to take effect for the following year. The exception to this Internal Revenue Service regulation is a change in family or job status, which allows you to make the appropriate benefit changes mid-year. Only changes that are on account of and correspond with the documented family or job status event can be made. Qualifying life event changes are marriage, divorce, birth or adoption of your child, death of a covered family member, change in child dependent status, or loss of your spouse's health care coverage.

PERSONAL INFORMATION

Name _____ Empl ID _____

Address _____

City _____ State _____ Zip Code _____

Home/Cell Phone _____ E-mail _____

Business Phone _____ Gender: M F Married: Y N Date of Marriage _____

LIFE EVENT (*Please provide a brief explanation of the life event circumstances and date of event in the space provided.* Documentation verifying the date of event must accompany this change of status form).

_____

_____

_____

_____

DEPENDENT INFORMATION

Dependent verification documents must be submitted with enrollment form if adding new dependent. Do NOT fax or email forms containing sensitive information.

Relationship	Last (if different)	First	Date of Birth	Gender	Soc Sec No.	WSp Pre	DepVer	Init
Spouse or Equivalent				M F				
				M F				
				M F				
				M F				

Please select an insurance carrier and coverage level for each benefit being changed or select Waive for no coverage.

The amount you pay depends on the university's contribution. See separate price sheet for details.

HEALTH COVERAGE

*** Election of Employee+Spouse or Family requires completion of the Working Spouse Premium form.**

MMO SuperMed PPO **MMO CLE-Care HMO** **MMO SuperMed High Deductible Health Plan** **Waive Health Coverage**

Level of coverage: **Employee Only** **Employee + Child(ren)** **Employee + Spouse/Equiv*** **Family***

DENTAL COVERAGE

Superior Dental Care **School Dental Med Comprehensive** **Waive Dental**

Level of coverage: **Employee Only** **Employee + Child(ren)** **Employee + Spouse/Equivalent** **Family**

MEDICARE AND OTHER INSURANCE INFORMATION

If covered by Medicare/Medicaid: Medicare ID#. Effective Date ESRD Onset Date

You

Your Spouse

Do you or any of your dependents have other health or dental coverage? Yes No If yes, complete below

Name of policy holder Name and address of insurance company Policy No. Effective Date Coverage Type

VISION COVERAGE

VSP **Waive Vision**

Level of coverage: **Employee Only** **Employee + Child(ren** **Employee + Spouse/Equivalent** **Family**

FLEXIBLE SPENDING ACCOUNT PLANS

Flexible spending account minimum annual contribution is $120. Maximum for health care is $2,850, Unspent dollars in calendar year are forfeited. You cannot contribute to the health care flexible spending account if you participate in the MMO High Deductible health plan.

Health Care Flexible Spending Account **Monthly pledge** _____ **Waive Medical FSA**

Dependent Care *(annual maximum $2,500 if married filing separate tax returns)* **Monthly pledge** _____ **Waive Dependent FSA**

HEALTH SAVINGS ACCOUNT *(only available if health plan selected is MMO High Deductible Health Plan)*

Health Savings Account **Annual pledge** **Waive Medical HSA**

LIFE AD/D COVERAGE

Please mark your selection. *Medical evidence of insurability is required for supplemental elections. Maximum coverage allowed is 3 x salary, but not more than $500,000.*

1X **1.5X** **2X** **2.5X** **3X** **50,000** **Waive Life AD/D**

DEPENDENT LIFE *(Voluntary After-tax Benefit)*

$5,000 Spouse/$1,000 Child(ren) 1.00/month **$10,000 Spouse/$2,000 Child(ren) 2.00/month** **Waive Dependent Life**

EMPLOYEE SIGNATURE

*I understand that by signing and submitting this form **within 30 days of the qualifying status change,** I am making a binding election concerning my benefits until such time as I elect new coverage and sign a new form. If I elected to waive medical coverage, I certify that my family and I have other coverage.*

Signature _____ Date _____

Return completed form and dependent verification to Benefits Administration, 320 Crawford Hall, LC 7047.

CWRU BENEFITS ADMINISTRATION

Coverage effective date _____

☐ Supplemental Life EOI Received ☐ Dependent Life EOI received Date _____

Benefits Representative Signature