BENELECT 2027 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:		EMPLID:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Email:
Birth Date:	Gender: M ☐ F ☐	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. Do ***NOT*** send forms containing sensitive information via email or fax.

Relationship	Last (only if different	First	Birth Date	Gender	Soc. Sec. No.	Dep Ver
Spouse/Equiv				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.**

Choose your plan:

- ☐ SuperMed PPO
- ☐ Medical Mutual High Deductible Health Plan
- ☐ CLE Care HMO
- ☐ WAIVE

Choose your coverage level:

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Equivalent*
- ☐ Family*

DENTAL COVERAGE

Choose your plan:

- ☐ Superior Dental Care
- ☐ CWRU School of Dental Medicine
- ☐ WAIVE

Choose your coverage level:

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/Equivalent
- ☐ Family

CASE WESTERN RESERVE UNIVERSITY
Department of Human Resources

VISION COVERAGE

Choose your plan:

☐ VSP

☐ WAIVE

Choose your coverage level:

☐ Employee Only

☐ Employee + Child(ren)

☐ Employee + Spouse/Equivalent

☐ Family

SAVINGS ACCOUNTS

Flexible Spending Account (FSA)

FSA minimum annual contribution is $120; maximum of $3,500 is the maximum annual amount for 2027

☐ Health Care Flexible Spending Account

_____ Annual pledge

☐ WAIVE

Dependent Care Spending Account (DCSA)

DCSA maximum is $2,500 per year for individuals; $7,500 per year if married filing separate tax returns

☐ Dependent Care Flexible Spending Account

_____ Annual pledge

☐ WAIVE

Health Savings Account (HAS)

Available only if enrolling in the High Deductible Health Plan. The annual maximum is $4,400 per year for individuals; $8,750 per year for families

☐ Health Savings Account

_____ Monthly pledge

☐ WAIVE

LIFE AD/D COVERAGE

SUPPLEMENTAL LIFE AND AD/D COVERAGE
(Max coverage allowed is 3 x salary, but not more than $500,000.)

☐ 1.0X

☐ 1.5X

☐ 2.0X

☐ 2.5X

☐ 3.0X

☐ $50,000

☐ WAIVE

DEPENDENT LIFE (After-tax benefit)

☐ $5,000 Spouse/$1,000 Child(ren) | $1.00/month

☐ $10,000/Spouse/$2,000 Child(ren) | $2.00/month

☐ WAIVE

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

☐ Supplemental Life **☐ Dependent Life**

EOI Received **EOI received**

Benefits Representative Initials Date