Changing Benefit Elections

This packet includes all the forms needed to change your current benefit elections. This packet is not to be used for new hire enrollees.

To be eligible to change benefit elections outside of the annual enrollment period you must have:

1) Experienced an applicable Qualifying Life Event, as defined by the Internal Revenue Service (IRS). Changes based on financial reasons alone are not allowed under the current IRS regulations.

AND

2) The request for a change of benefits must be made within **30 days** of the applicable Qualifying Life Event. Changes for Medical will be effective the day of the Qualifying Life Event and for Dental and Vision, it will be the first of the next month following the Qualifying Life Event.

"Applicable" refers to a change that is directly related to the individual experiencing the Qualifying Life Event. Examples of "Qualifying Life Events" include, but are not limited to:

- A Birth or an Adoption.
- Marriage, Divorce.
- Death of a Spouse or Dependent.
- Child loses eligibility because of age or marriage.
- Employee's spouse gains or loses coverage through employment.

This packet includes the following forms:

Qualifying Life Event Checklist

1) Check the applicable Qualifying Life Event.
2) Note: The effective date of the Qualifying Life Event and the individual the Qualifying Life Event pertains to.
3) NOTE: You will need to submit proof of your Qualifying Life Event, and verification document to proof your relationship to your dependents… example: Marriage Certificate, Birth Certificate…etc. along with the attached documents.

Benefit Election Form

1) Complete the top section with your personal information.
2) Circle "Change".
3) Add a brief description of the reason of the Qualifying Life Event.
4) In each benefit section, elect the new Tier level based on your Qualifying Life Event.
   a. Example: To ADD a newborn to an Employee + Spouse Tier, you would check ☑ the Family box, and beside "Child", fill in the child's information and write ADD under the appropriate coverages.
   b. To TERMINATE a dependent from an Employee + 1 Child Tier, you would check ☑ the Employee Only box, and beside "Child", fill in the child's information and write DROP under the appropriate coverages.
5) Sign and date the completed form.

Remember: You must return your completed forms, with signature and date, within 30 days of the Qualifying Life Event to Theresa Patton, Benefits Specialist in the Human Resources Department or you will have to wait until open enrollment to make changes to your plan.

Changing Benefit Elections

IRS Section 125 Qualifying Event Checklist		
In order to make a change that affects your pre-tax medical, dental, or vision premiums, you will need to indicate the Qualifying Life Event that is consistent with such a change. (check all that apply) ***All changes must be made within 30 days of the Qualifying Life Event, Failure to do so will result in waiting until the next open enrollment to make the change.***		
Change in Legal Marital Status	**Effective Date of Change**	**Name of Individual**
❑ Marriage (excludes common-law)		
❑ Divorce/Legal Separation		
❑ Death of Spouse		
Change in Number of Dependents or Eligible status	**Effective Date of Change**	**Name of Individual(s)**
❑ Birth		
❑ Adoption/Placement for Adoption		
❑ Attained age 26		
❑ Marriage of dependent child		
❑ Death of dependent child		
Gain/Loss of Other Coverage	**Gain/Loss Date**	**Name of Individual(s)**
❑ Termination of Employment/Loss of coverage Name of other group insurance >		
❑ Commencement of Employment/Gain of coverage Name of other group insurance >		
❑ Strike or Lockout		
❑ FMLA (going on or returning from)		
Other		
❑ Other Reason:____		
❑ Change of Custody, Judgment, Court Order or Decree requiring medical coverage including qualified Medical Child Support Orders (QMCSO): If employee has court order to cover a dependent child(ren), changes must be consistent with order.	Date of Order	Name of Dependent(s)

Employee's Signature and Date	
Your signature confirms that all statements herein are true. Documentation that authenticates these statements will be required upon submission of this form.	
Print Name:	**Employee #:**
Signature:	**Date:**

This completed original form, proof of qualifying life event and Benefit Election Form, must be returned to:

Iredell County Government
Human Resources Office

Benefits Change Form

Effective Date:		
Employee Information ***(Please print clearly)***		
SS#:	Date of Birth:	Marital Status: Married / Single
Employee #:	Job Title:	Gender: M / F
Name (First Name M.I. Last Name):		Annual Salary:
Address:		Phone #:

Place "X" in the box to elect your coverage

Coverage	Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Family	Decline
Health Insurance	☐ PPO Base ☐ HSA ☐ PPO Buy Up	☐ PPO Base ☐ HSA ☐ PPO Buy Up	☐ PPO Base ☐ HSA ☐ PPO Buy Up	☐ PPO Base ☐ HSA ☐ PPO Buy Up	☐ PPO Base ☐ HSA ☐ PPO Buy Up	
Dental	☐ Low Plan ☐ High Plan	☐ Low Plan ☐ High Plan		☐ Low Plan ☐ High Plan	☐ Low Plan ☐ High Plan	☐
Vision	☐Comprehensive ☐ Eyewear	☐Comprehensive ☐ Eyewear		☐Comprehensive ☐ Eyewear	☐Comprehensive ☐ Eyewear	☐
Waive Medical Coverage	☐ Opt out with up to $2,000 reimbursed in Medical Claims on other plan with HRA ☐ Opt out with **<u>NO</u>** HRA					

Covered person(s) For all of these benefits as well as Allstate Accident-Transamerica Cancer- Transamerica Critical Illness*(Please print clearly)*

First Name M.I. Last Name	<u>SS#</u> xxx-xx-xxxx	<u>Birth Date</u> xx/xx/xxxx	<u>Gender</u> M/F	<u>Relationship</u> Spouse, Child, Stepchild, etc.	Coverage Elected (X)		
					Medical	Dental	Vision
Spouse:							
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							

- My coverage elections on this form cannot be revoked or modified during the year unless I have a qualifying change in status as defined by the IRS; I may, however, change my coverage elections during the next open enrollment period for any reason.
- By choosing coverages on this form, I authorize my employer to deduct the applicable weekly pre-tax employee co-premiums from my paycheck. <u>This payroll deduction and authorization will remain in effect until the next open enrollment or unless a coverage change is permitted consistent with IRS rules and regulations.</u>
- I will be responsible for the premium payments in the event that I have insufficient worked hours and no paid time available to cover such premium payments.
- If enrolling in medical benefits with spouse coverage, I do attest that, my spouse is not eligible for coverage elsewhere.
- I and any dependents listed for coverage are eligible for coverage. I understand that enrollment in benefits to which I or my dependents are not entitled is considered fraud and legal action may be taken against me and I may be subject to disciplinary, up to and including termination.
- I understand that by declining coverage that meets the Federal Government's requirement that the health coverage offered must provide minimum essential coverage and be affordable with the cost no more than 9.5% of my W-2 wages.

Employee Signature: ____ Date Signed: ___________________

HR Representative Signature: _______________________________________ Date Signed: ___________________