Benefit Enrollment Change Form

Due to IRS regulations, the annual open enrollment period is the only time you may change your benefit elections, unless you have a qualifying life event such as: marriage, divorce, legal separation, birth or adoption of a child, death of a spouse or dependent child, change in your or your spouse's employment status, or change in a dependent's full-time student status. You must make the change to your benefits within 31 days of the qualifying life event; otherwise you must wait until the next annual open enrollment period to change your coverage.

HIPAA Special Enrollment Rights
A team member or dependent covered under Medicaid or a state's Children's Health Insurance Program has 60 days to enroll in benefits if no longer eligible for Medicaid or CHIP.

A team member or dependent who becomes eligible for Medicaid or CHIP assistance (i.e. becomes eligible for help in paying benefit premium costs) has 60 days to enroll in benefits after the eligibility determination date.

Section 1:

Team Member Name: _____ **Team Member Number:** _____

Today's Date: _____ **SS# - last 3 digits only:** _____

Home Phone #: _____ **Work Phone #:** _____

Section 2:

Effective date of qualifying life event: _____

Qualifying Life Event (please select one):

☐ **Marriage, divorce or legal separation***
☐ **Death of a spouse or dependent child***
☐ **Change in your spouse's employment status***
☐ **Change in your spouse's benefit status***
☐ **Birth or adoption of a child***
☐ **Change in your employment status**
☐ **Change in a dependent's full-time student status**

***For these qualifying life events, please attach documentation such as a marriage certificate, divorce papers, death certificate, adoption papers, or proof of termination of benefits/employment. The effective date for all except birth or adoption of a child is first of the month following the date of the life event.*

A. If the qualifying event is the birth or adoption of a child, please fill-in the following information:

Child's Name: _____

Child's Date of Birth: _____ **Child's Sex:** ☐ **Male** ☐ **Female**

B. If the qualifying event is a change in your employment status or your spouse's employment status, please outline what has changed and provide documentation from your spouse's current/former employer:

_____

_____

_____

C. If the qualifying event is anything other than the birth or adoption of a child or change in your employment status, please fill-in the following information for the dependent(s) you wish to add to or to remove from your benefits.

Dependent's Name: _____

Social Security #: _____ **Date of Birth**: _____
Gender: ☐**Male** ☐**Female** **Benefit Change** ☐**Add** ☐**Delete**

Dependent's Name: _____

Social Security #: _____**Date of Birth:** _____
Gender: ☐**Male** ☐**Female** **Benefit Change** ☐**Add** ☐**Delete**

Dependent's Name: _____

Social Security #: _____ **Date of Birth**: _____
Gender: ☐**Male** ☐**Female** **Benefit Change** ☐**Add** ☐**Delete**

Please check your benefit changes below:

Medical

Meridian Value Plan	☐**Add**	☐**Delete**
QualCare Inner Circle Plan	☐**Add**	☐**Delete**
QualCare CDHP Plan	☐**Add**	☐**Delete**

Dental

Horizon Dental Option Plan (Gold)	☐**Add**	☐**Delete**
Horizon PPO Preventive Plan (Silver)	☐**Add**	☐**Delete**
Horizon Dental Choice Plan (Bronze)	☐**Add**	☐**Delete**
Healthplex Dental Plan	☐**Add**	☐**Delete**

Vision

United Vision Plan	☐**Add**	☐**Delete**

Flexible Spending Accounts

Medical FSA
☐ **Add** ☐ **Delete** ☐ **Change**
Indicate amount for remainder of calendar year: $_____ (Min $130/Max $2,500)

Dependent Care FSA
☐ **Add** ☐ **Delete** ☐ **Change**
Indicate amount for remainder of calendar year: $_____ (Min $130/Max $5,000)

Team Member Signature: _____
Date: _____

FAX COMPLETED FORM AND SUPPORTING DOUCMENTATION TO
HR SUPPORT SERVICES AT *732-751-7542* or
EMAIL IT TO *HUMANRESOURCESBENEFITS@MERIDIANHEALTH.COM*