BENELECT 2015 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

Address

City State Zip Code

Home/Cell Phone Business Phone E-mail

Birth Date 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)

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Last (if different)</th>
<th>First</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Soc Sec No.</th>
<th>W3p Pre</th>
<th>DepVer</th>
<th>Init</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse or Equiv</td>
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<td>M F</td>
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</tr>
</tbody>
</table>

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 Emp+Spouse or Family requires completion of the Working Spouse Premium form.

- [ ] Anthem PPO
- [ ] MMO SuperMed PPO
- [ ] HealthSpan HMO
- [ ] Anthem High Deductible Health Plan

- [ ] Waive Health Coverage

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

High Deductible Plan only:  
- [ ] Health Savings Account  
- [ ] Waive Health Savings Account  
  Monthly pledge $ 

DENTAL COVERAGE

- [ ] DenteMax  
- [ ] School Dental Med Comprehensive  
- [ ] Waive Dental

Level of coverage:  
- [ ] Employee Only  
- [ ] Employee + Child(ren)  
- [ ] Employee + Spouse/Equivalent  
- [ ] Family
### MEDICARE AND OTHER INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>If covered by Medicare/Medicaid:</th>
<th>Medicare ID#:</th>
<th>Effective Date</th>
<th>ESRD Onset Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Your Spouse</td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of policy holder</th>
<th>Name and address of insurance company</th>
<th>Policy No.</th>
<th>Effective Date</th>
<th>Coverage Type</th>
</tr>
</thead>
</table>

### VISION COVERAGE

<table>
<thead>
<tr>
<th>VSP</th>
<th>Level of coverage:</th>
<th>Employee Only</th>
<th>Employee + Child(ren)</th>
<th>Employee + Spouse/Equivalent</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Union Eye Care</td>
<td>Level of coverage:</td>
<td>Employee Only</td>
<td>Employee + 1</td>
<td>Family</td>
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<tr>
<td>Waive Vision</td>
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### FLEXIBLE SPENDING ACCOUNT PLANS

Flexible spending account minimum annual contribution is $120. Maximum for health care is $2,550. Unspent dollars in calendar year are forfeited. You cannot contribute to the health care flexible spending account if you participate in the Anthem 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 Anthem High Deductible)

- Health Savings Account  
  Monthly pledge $______________

### 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  
- Waived

### 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, 224 Crawford Hall, LC 7047.

### CASE BENEFITS ADMINISTRATION

Date of Change  
Coverage effective date

Benefits Representative Signature  
Date

Rev 10/2014