Benefit Change Form Instructions

Background:

Benefit Change Forms are used during special enrollment periods when employees can make changes to their benefit elections. These time frames are Open Enrollment, New Hire Enrollment, and Qualifying Life Events(QLEs).

To ensure accuracy, please follow the instructions below when it comes to the different sections of the Benefit Change Form. This allows the benefits team to know exactly what you desire to accomplish.

1.

CarleHealth **Benefit Enrollment / Change Form**

Must be received by Carle Benefits on or before 31 days from qualifying life event to receive benefits

Effective Date					
Name Last name, first name, middle initial	Former Name (if changing)	Team Member Badge Number			
Current Address ☐ Check if new address	City	State	Zip	Home Phone	
Marital Status ☐Single ☐Married ☐Divorced ☐Widowed	Tobacco User ☐ Yes ☐ No	Social Security #	Sex	Birth date	Work Phone

☐ Initial Enrollment ☐ Family Status Change (requires documentation)

Reason for submitting change form (written documentation is required, ie. marriage/ birth certificate etc.)	☐ Marriage date___	☐ Birth of child or adoption date___	☐ Dependent over age date___	☐ Other (Please describe)___ date___
	☐ Divorce or Legal separation date___	☐ Death date___	☐ Change in employment status date___	☐ Cancellation date___

Please make sure all the information above is filled in correctly (especially badge number, SSN, name, and the reason for submitting request.) These key areas provide indication for the parameters around the event you are submitting for. Please see the Qualifying Life Event guide on Benefits.Carle.org for reasons.

2.

Benefit Coverage Options (please select which coverage(s) you wish to elect/make changes to)

Health ☐PPO ☐HDHP	☐ No Change	☐ Decline/Remove Coverage	☐ Team Member Only	☐ Team Member + Spouse/ Domestic Partner	☐ Team Member + Children	☐ Family
Dental ☐Standard ☐Enhanced	☐ No Change	☐ Decline/Remove Coverage	☐ Team Member Only	☐ Team Member + Spouse/ Domestic Partner	☐ Team Member + Children	☐ Family
Vision	☐ No Change	☐ Decline/Remove Coverage	☐ Team Member Only	☐ Team Member + Spouse/ Domestic Partner	☐ Team Member + Children	☐ Family
Accident	☐ No Change	☐ Decline/Remove Coverage	☐ Team Member Only	☐ Team Member + Spouse/ Domestic Partner	☐ Team Member + Children	☐ Family
Hospital Indemnity	☐ No Change	☐ Decline/Remove Coverage	☐ Team Member Only	☐ Team Member + Spouse/ Domestic Partner	☐ Team Member + Children	☐ Family
Critical Illness *Select all that apply*	☐ No Change	☐ Decline/Remove Coverage	☐ Team Member Only ☐ $10K ☐ $20K ☐ $30K	☐ Spouse/ Domestic Partner ☐ $5K ☐ $10K ☐ $15K *Must have Critical Illness Team Member coverage to elect*	☐ Children - ☐ $5K ☐ $10K *Check one amount above for selected child(ren) in section below* *Must have Critical Illness Team Member coverage to elect*	
Legal Services	☐ No Change	☐ Decline/Remove Coverage	☐ Legal Services			
LifeLock Identity Theft Protection	☐ No Change	☐ Decline/Remove Coverage	☐ Essential Coverage		☐ Premier Coverage	
Spouse/Domestic Partner Life	☐ No Change	☐ Decline/Remove Coverage	☐ Spouse/ Domestic Partner Desired Amount $___ *Amounts in $1,000 increments up to the lesser of $50,000 or 1X your annual salary*			
Dependent Life	☐ No Change	☐ Decline/Remove Coverage	☐ Child(ren) - ☐ $5K ☐ $10K ☐ $15K *Check one amount above for selected child(ren) in section below*			
Supplemental Life - 5x Basic Annual Earnings (includes basic life), purchased in $10,000 increments. Maximum of $1 million		☐ No Change	☐ Decline/Remove Coverage	☐ Supplemental Life Desired Amount $___		
AFLAC Short-Term Disability – Up to 60% of salary in increments of $100, up to the maximum for your assigned employment status		☐ No Change	☐ Decline/Remove Coverage	☐ Short-Term Disability Desired Amount $___		

For the section above, you need to check the box for the *benefit coverage you want to have after the submission of the current change form.* If you are not changing coverage in for the particular benefit, *check no change*. See examples below.

a. If you currently have Health- Team Member only coverage and are wanting to add a child with this event. You will want to check Health-Team Member + Children.

b. If you currently have Dental-Family but are removing the dependent children from the plan, you will check Dental-Team Member+ Spouse Domestic Partner
c. If you currently have Vision-Family and are removing one dependent, but will still have another one remaining on the plan along with the spouse, leave the coverage as Vision-Family
d. If you currently have Accident- Team Member+ Children and are looking to totally remove accident insurance, select Decline/Remove Coverage
e. If you currently have Hospital Indemnity coverage, and are solely looking to add Health coverage, select No Change under Hospital Indemnity.
f. If you are looking to change amounts for and Dependent, Supplemental Life, or Aflac Coverage, please insert the amount you are looking to have it changed to. Keep in mind this may have to accompany an Evidence of Insurability Form if you are looking to increase Life Insurance.

*If newly enrolling on health plan please select PPO or HDHP.

*If newly enrolling on dental plan please select standard or enhanced.

3.

Please complete family member section below for coverage for eligible family members. Family members may only be covered under the plan if you have chosen it for yourself. Life coverage can only be elected within 31 days of a qualifying event (ie., first eligible, marriage or birth) otherwise additional forms must be completed.

INDICATE FAMILY BENEFIT INSURANCE COVERAGES IN THIS SECTION

Family members	Sex	Birthdate MM/DD/YY	Social Security Number	Uses Tobacco Products	Check One		Coverage							
Last name, First name & Mid Initial					Add	Remove	Health	Dental	Vision	Accident	Hospital Indemnity	Critical Illness	Life Lock	Life Ins.
Spouse/Domestic Partner				☐ Yes ☐ No										
Dep. Child				☐ Yes ☐ No										
Dep. Child				☐ Yes ☐ No										
Dep. Child				☐ Yes ☐ No										
Family members address if canceling their coverage.					City, State, Zip									

For the section above, you need to fill in all information for the individual(s) you are wanting to add or remove *benefit coverage for with the submission of the current change form.*

You also *only need to fill out sections for the individuals having changes made to them*, do not include inviduals not having changes made for them.

If you are adding or removing one or more forms of coverage on an individual but not changing others, *leave the unchanged benefits blank*. (Ex, if Spouse has dental, you are adding vision and leaving dental, check Add and then check Vision, leave Dental blank)

4.

Team member's Signature ______________________ Date ____________

Make sure to sign and date the forms as they are not valid without a signature.

If you have questions while filling of the forms, please reach out to the MyHR.Helpdesk@carle.com or call 217-902-5300

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Current Address ☐ Check if new address	City	State	Zip	Home Phone

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☐ **Initial Enrollment** ☐ **Family Status Change** (requires documentation)

Reason for submitting change form (written documentation is required, ie. marriage/ birth certificate etc.)	☐ Marriage date ___________	☐ Birth of child or adoption date ___________	☐ Dependent over age date ___________	☐ Other (Please describe)___________ date ___________
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INDICATE FAMILY BENEFIT INSURANCE COVERAGES IN THIS SECTION

Family members Last name, First name & Mid Initial	Sex	Birthdate MM/DD/YY	Social Security Number	Uses Tobacco Products	Check One: Add	Check One: Remove	Coverage: Health	Dental	Vision	Accident	Hospital Indemnity	Critical Illness	Life Lock	Life Ins.
Spouse/Domestic Partner				☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dep. Child				☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dep. Child				☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dep. Child				☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Family members address if canceling their coverage.	City, State, Zip

Premiums for applicable group health and dental will automatically be deducted on a pre-tax basis unless I sign a separate waiver form. Waiver forms are available in the Benefits office. I understand that I am only permitted by law to change the election for the Carle Foundation Flexible Compensation Plan on the anniversary date, unless I have a change in family circumstances—marriage, divorce, birth or adoption of a child, death of my spouse or child, employment or termination of employment of my spouse. I further understand that I have 31 days from the date of my family circumstance change to change my health and/or dental election. If no plan type is chosen for the health and/or Dental Plan and no response is received to let Benefits know a preference by the end of the 31-day window then the default plan types of PPO Health and Standard Dental will be enrolled

I also certify that all information recorded in the application is true and correct to the best of my knowledge and belief. I have read and understand the tobacco use affidavit attached to this form and answered the applicable questions on this form honestly. I further understand that any misrepresentation, misstatement, or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application. In the event this application is approved prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in termination of the plan document effective as of the date of the member's enrollment, and any such member, or responsible parent or guardian in the case of a minor, shall be required to reimburse Carle Foundation, or its successors, agents or assigns, for any and all sums expended on his or her behalf for health and or dental care services together with reasonable attorney's fees and expenses incurred in collection of such sums

Team member's Signature ____ **Date**_______________

All covered health insurance participants are REQUIRED to read the Tobacco Use Affidavit and answer honestly on the change form.

My signature on the health, dental and/or life enrollment/change form certifies that I have read and understand the below statements.

1. The responses contained in the boxes on the change form accurately and truthfully reflect tobacco usage by me and/or my covered dependents.
2. I understand that the definition of tobacco products for use in this Affidavit includes cigarettes, cigars, chewing tobacco, pipe tobacco, and or any other tobacco product regardless of the frequency or method of use.
3. I understand that I and/or my covered dependents will have the opportunity to qualify for the non-tobacco user premium at least once a year by submitting a revised Affidavit or by taking advantage of the reasonable alternative standard Carle provides.
4. I understand that if I fail to complete this Affidavit truthfully, Carle may take adverse employment action against me up to and including termination of my employment because an untruthful response constitutes falsification of a document in violation of the Team Member Discipline and Misconduct Policy.
5. I understand that if it is medically inadvisable for me or my covered dependents to attempt to meet the requirements of this program, Carle will make available a reasonable alternative standard for me and/or my covered dependents so that I may avoid the tobacco-user surcharge.
6. I further understand that the reasonable alternative standard will include, but may not be limited to, my participation in the Smoking Cessation Program, *Quit for Life.*
7. I understand that if Carle obtains information establishing that I or my covered dependents use tobacco products and did not participate in the Smoking Cessation Program, *Quit for Life*, Carle will implement the higher tobacco-user premium regardless of the representations I make on this Affidavit.

You will be eligible to avoid the tobacco-user premium rate if you are able to certify that you and/or your covered dependents do not use tobacco products.