2025 Status Change Election Form

EMPLOYEE INFORMATION

Employee Name: _____ Employee ID: _____

Phone: _____ Email: _____

In accordance with IRS regulations, benefit elections may be changed only during Open Enrollment or in the event of a qualifying life event. All changes (except birth or adoption of child) must be made on a prospective basis only. **Human Resources must receive this form, supporting documentation and an Employed Spousal Affidavit (if applicable) no later than 31 days after the event.**

Date Status Change Occurred: _____

Reason for Status Change: (check box below)

☐ Newly Eligible for Benefits ☐ Birth ☐ Marriage

☐ Obtained Other Coverage ☐ Adoption ☐ Divorce

☐ Loss of Coverage ☐ Guardianship ☐ Death of Dependent

☐ Other (describe) _____

MEDICAL

These amounts are pre-tax & deducted every pay period.

Full-Time employees = 28 – 40 standard hours | Part-Time employee = 20 – 27 standard hours

Insurance Plan	Employee	EE + Spouse	EE + Child(ren)	Family	Waive
BCBS Consumer Driven	☐ $58.79	☐ $141.02	☐ $129.20	☐ $197.77	☐ $0
BCBS CDHP Part-Time	☐ $90.40	☐ $207.42	☐ $189.28	☐ $295.78	☐ $0
BCBS PPO	☐ $103.86	☐ $228.20	☐ $209.43	☐ $310.01	☐ $0
BCBS PPO Part-Time	☐ $142.03	☐ $308.36	☐ $281.95	☐ $428.33	☐ $0
DENTAL					
BCBS Dental Basic	☐ $9.68	☐ $21.31	☐ $16.50	☐ $36.82	☐ $0
BCBS Dental Buy-Up	☐ $14.16	☐ $31.15	☐ $24.14	☐ $53.85	☐ $0
VISION					
VSP Vision	☐ $4.45	☐ $8.82	☐ $8.71	☐ $12.31	☐ $0
EyeMed Vision	☐ $4.45	☐ $8.82	☐ $8.71	☐ $12.31	☐ $0

DEPENDENT INFORMATION

Name	Relationship	SSN	Birthdate	Gender	Select coverage for dependent: Med	Den	Vision	Dep Life
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

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FSA – Flexible Spending Accounts	Coverage Amount	
Healthcare FSA (Medical, Dental, Vision)	$	($3,300 max)
Limited Purpose FSA (Dental, Vision)	$	($3,300 max)
Dependent Care FSA (Daycare, Childcare)	$	($5,000 max)

HSA – Health Savings Account*	Coverage Amount
*HSA is only available to BCBS CDHP Participants $3,550 max for single + $750 ($4,300 total) $7,050 max for family + $1,500 ($8,550 total)	$

MUST BE COMPLETED IF CARRYING SPOUSE ON MEDICAL COVERAGE		
Employed Spouse Provision: Your spouse may not be covered as primary on your COA medical plan if he/she is eligible for another employer sponsored group coverage and that employer pays at least 50% of the premium. If spousal coverage is elected, please complete the section below. (Does not apply to dental or vision.)		
Is your spouse employed? (check the box that applies)		
☐Yes. You must have your spouse's employer complete the Employed Spousal Affidavit.		
☐Yes, self-employed with no access to Group Benefits.		
☐Yes, employed by Children's of Alabama		
☐No, my spouse is not employed.		
If your spouse does not qualify for primary coverage through our COA plan you may elect secondary coverage: I elect secondary coverage for my spouse ☐Yes ☐No		
Spouse's primary insurance carrier:		*Submit a copy of your spouse's insurance ID card through his or her employer (primary coverage) with this form.*
Group #:		
Subscriber #:		

SUPPLEMENTAL TERM LIFE INSURANCE	Current Amount	New Amount
Employee Supplemental Life You may elect coverage in $50,000 increments up to $700,000. *Conditional Guaranteed Issue up to $300,000.	$	$
Spouse Supplemental Life You may elect coverage in $10,000 increments up to $100,000. *Conditional Guaranteed Issue up to $30,000 if your spouse can perform the normal activities of a person the same age and gender (not disabled.)	$	$
Dependent Supplemental Life Provides $10,000 coverage for all eligible dependents. $1,000 of coverage for 14 days to six months.	$	$

Note: If employee and spouse are both employed at COA, Spouse Life coverage is not available and only one parent may cover children under Dependent Life.

*An Evidence of Insurability must be submitted with applications over the Guaranteed Issue amounts above; coverage will not be effective until approved by The Hartford. Guaranteed Issue is available only if applying within 31 days of first becoming eligible or during Open Enrollment.

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BENEFICIARY DESIGNATION

Click on My Beneficiaries in My Service Center to access The Hartford Beneficiary Designation Service website: https://enroll.thehartfordatwork.com/chabene
Your username will be your first and last initial (lower case only) and the last 4 digits of your SSN.
Your initial password will be your first and last initial and your birthday as mmddyyyy.
You will be prompted to reset your password, also called PIN throughout the site.
You can view, edit and add primary and contingent beneficiaries for Basic Life, Accidental Death & Dismemberment (AD&D), Supplemental Life, Voluntary Accident and Voluntary Hospital Indemnity plans.
Verify that your beneficiaries name, address and birthday are correct.

UNDERSTANDING OF BENEFIT ELECTIONS, AUTHORIZATION & CERTIFICATE

I understand that the above selections are for the remainder of the plan year unless I experience a qualifying status change and make corresponding election changes within 31 days of that event.

I certify that the information provided in this application is accurate and I understand the conditions of benefits as described below:

- I understand that the above selections are for the remainder of the plan year unless I experience a qualifying event and make corresponding election changes within 31 days of that event.
- To cover a dependent under any benefits I must provide a SSN, marriage certificate, birth certificate and proof of guardianship, if adopted. Failure to provide required supporting documentation will result in removal of the dependent from coverage until the next open enrollment period or qualifying status change.
- To cover my spouse on a COA medical plan I must submit an Employed Spousal Affidavit if my spouse is employed.
- Supplemental Life Insurance elections over the Guaranteed Issue amount require an Evidence of Insurability form to be completed. Your coverage will not be effective until approved by the carrier.
- My FSA and HSA contribution elections, if any, will end on December 31st of each year. Contributions to a Dependent Care FSA not used by the end of the plan year will be forfeited. Contributions to the HealthCare FSA are eligible for a carryover feature that allows up to $660 of unused funds to rollover to the following plan year
- If I elected the BCBS Consumer Driven Medical Plan with an HSA and I also elect a Healthcare FSA, my use of the FSA is limited to vision and dental expenses
- If I am covered under the BCBS Consumer Driven Plan I am not permitted to establish or contribute to an HSA if any of the following apply:
    - I am covered under another health plan that is not a high deductible plan
    - I become enrolled in Medicare
    - I am capable of being claimed as a dependent on another person's tax return

I hereby accept all designations made on this application and decline all other benefits that were not elected. In the event of any differences between the enrollment form and the insurance policy, I agree to be bound by the insurance policy. My signature on this form requests the coverage provided and authorizes the required deduction(s) from my wages.

Employee Signature: _____ Date: _____