Benefits Enrollment/Change Form

Use this form to make a change in benefits due to a qualifying event or status change.

Name: _____ Teammate ID: _____

Email Address: _____

Effective Date of Change: _____

Teammates may request mid-year changes to benefits when they experience a Qualifying Event. Requests for changes must be submitted within 31 days of the Qualifying Event along with supporting documentation.

Important Things to Remember

1. Type or write legibly. Complete all sections. Incomplete forms cannot be processed
2. **Include all necessary Supporting Documentation** (See list of documentation needed.)
3. Visit teammates.atriumhealth.org/2020-benefits-guide for detailed plan information including premiums, plan summaries, tools and resources and benefits contact information
4. Ensure beneficiaries for life insurance plans, retirement plans and HSA are updated
5. See last page of document for additional information

Please select your Qualifying Event:

Qualifying Event	Documentation Needed
☐ Marriage	Marriage Certificate
☐ Divorce/Separation	Divorce | Annulment | Separation Papers
☐ Adoption or Birth	Birth | Adoption Certificate
☐ Death of Dependent	Death Certificate
☐ Loss or Gain of Coverage	Letter from Provider or Copy of Insurance Card Showing Date Coverage Started/Ended
☐ Other _____ Examples: Status Change, Appeal, etc.	

Do the following apply:

Smoker/Tobacco User

Do you or any of your dependents (spouse or children) that you are selecting to cover smoke or use tobacco products?

☐ **Yes**
If yes, are **all** smoker/tobacco users that you have elected to cover participating in a Smoking/Tobacco Cessation Program?

☐ Yes ☐ No - Tobacco User Plan Rates may apply.

If it is unreasonably difficult due to a medical condition for you or anyone you cover under your medical plan to cease tobacco usage, or if it is medically inadvisable for you or anyone you cover under your medical plan to make this attempt, please contact Benefits Administration at 704-631-0263 for assistance in developing another way to receive the non-tobacco medical plan rate.

☐ **No**

Working Spouse

Is your spouse eligible for group health benefits coverage through his/her employer?

☐ **Yes** (Working Spouse Rate applies unless your spouse works for Atrium Health.)
If applicable, enter spouse's Atrium Health Teammate ID: _____

☐ **No** (Working Spouse Rate will NOT apply.)

Atrium Health

LiveWELL Health Plans

Please indicate the plan and coverage level you would like to enroll in.

Note: Teammates currently enrolled cannot switch plans (until the open enrollment period), only coverage levels.

Health Savings Plan	
Teammate Only	☐
Teammate + Spouse	☐
Teammate + Child(ren)	☐
Teammate + Spouse + Child(ren)	☐

Health Savings Account (HSA) ☐

I authorize a 2020 bi-weekly contribution of $_____ to be made to my Health Savings Account.

The HSA is yours to save for current and future healthcare-related expenses, such as your deductible, coinsurance, and prescription medications. Your HSA is an important component of retirement savings. Teammates can make direct contributions to this account from their paycheck and one-time contributions.

The amount indicated above will be deducted from your pay on a pre-tax basis in equal amounts throughout the course of the plan year. The maximum IRS annual contribution is $3,550 for Teammate Only coverage or $7,100 for all other coverage levels for the plan year, and includes the sum of all teammate and employer contributions, such as incentives. An additional "catch up" contribution of $1,000 is permitted for teammates who will be age 55 or older any time during 2020.

☐ *Do not make changes to my current elections.*

Limited Purpose FSA (optional) ☐

I authorize a 2020 bi-weekly contribution of $_____ to be made to my Limited Purpose FSA.

Allows teammates to set aside pretax dollars to help pay for planned qualified medical, dental and vision expenses that occur during a 12-month period. This account is use it or lose it.

This amount will be deducted from my pay on a pre-tax basis in equal amounts throughout the course of the plan year. The maximum annual contribution is $2,700 for the plan year.

☐ *Do not make changes to my current elections.*

Waive ☐

Co-Pay Plan	
Teammate Only	☐
Teammate + Spouse	☐
Teammate + Child(ren)	☐
Teammate + Spouse + Child(ren)	☐

Flexible Spending Account (FSA) ☐

I authorize a 2020 bi-weekly contribution of $_____ to be made to my Flexible Spending Account.

Allows teammates to set aside pretax dollars to help pay for planned qualified medical, dental and vision expenses that occur during a 12-month period. This account is use it or lose it.

This amount indicated above will be deducted from your pay on a pre-tax basis in equal amounts throughout the course of the plan year. The maximum IRS annual contribution is $2,700 for the plan year.

☐ *Do not make changes to my current elections.*

LiveWELL Incentive Account

For teammates that are enrolled in the Co-Pay Plan, Atrium Health will deposit earned LiveWELL Incentives into this account during the year. Funds can be used to help pay for qualified medical, dental and vision expenses. Unused funds rollover from year to year. Employer-funded only, **no action is required.**

Waive ☐

Dental	
Teammate Only	☐
Teammate + Spouse	☐
Teammate + Child(ren)	☐
Teammate + Spouse + Child(ren)	☐
Waive	☐

Vision	
Teammate Only	☐
Teammate + 1	☐
Teammate + 2 or more	☐
Waive	☐

Dependents

Eligible Dependents include:

- Spouse
- Children up to age 26
- Disabled Children who:
  - Are unmarried
  - Incapable of self-support due to a mental or physical disability
  - Disability began prior to age 26

Please contact MedCost at 800-795-1023 for required disability forms.

Dependent Information and Enrollment Details

Name	Date of Birth	Relationship	Gender	Social Security Number	Medical	Dental	Vision
					Add/ Drop	Add/ Drop	Add/ Drop

If your dependent(s) reside(s) at a different address than yours, please complete the Dependent Information Change Form. Find this form on PeopleConnect > Human Resources > HR Forms > Dependent Information Change Form.

Dependent Care Flexible Spending Account

I authorize a 2020 bi-weekly contribution of $_____ to be made to my Dependent Care FSA. This amount will be deducted from my pay on a pre-tax basis in equal amounts throughout the course of the plan year. The maximum annual contribution is $5,000 or $2,500 if married and filing a separate tax return for the plan year.

☐ *Do not make changes to my current elections.*

Please carefully review enrollment materials for information on tax implications for highly-compensated teammates and those who also use the Dependent Care Backup Program. For additional questions, please contact your tax advisor.

Additional Benefits

You have 31 days from the day of your Qualifying Life Event to add, change, or drop coverage for the additional benefit plans. Indicate below if you are adding or dropping your current additional benefit below.

Note: If you choose to enroll in additional benefits, the minimum coverage will be elected. To increase plan coverage, you will need to visit the Atrium Health BenefitFocus Portal at https://peopleconnectmore.carolinas.org/aspxapps/ssoBenefitFocus

Indicate Additional Benefits to Add or Drop

□	Supplemental Life
□	Spouse Life
□	Dependent Life
□	Accidental Death\Dismemberment (AD\D)
□	Universal Spouse Life
□	Universal Dependent Life
□	Hospital Indemnity
□	Accident Insurance

□	Spouse AD/D
□	Dependent AD/D
□	Short -Term Disability Buy-up
□	Universal Life
□	Critical Illness
□	Identity Protection
□	Legal
□	Nationwide Pet Insurance

Acknowledgement

I affirm that the above information is true and correct to the best of my knowledge. My signature authorizes deductions from my paycheck where indicated and reflects my benefit decisions, including any coverage that has been added or dropped.

Teammate Signature: _____ Date: _____

Submit this completed form along with required supporting documentation to Benefits Administration.

Email as an attachment to HRBenefitsOnline@AtriumHealth.org or fax to 704-446-6623.

Additional Information

- According to IRS rules and regulations section 125, teammates cannot make changes to their benefits outside of Open Enrollment without a qualifying life event (QLE). If a teammate experiences a QLE, the teammate must submit changes along with the appropriate documentation within 31 days of the QLE.
- Teammates may not change or stop their spending account (excluding HSA) contributions during the plan year unless their family experiences a qualifying life event. Such a change in elections must be the result of, and consistent with, the event causing the election change, and must qualify under the terms and conditions of the plan.
- Health Savings Account (HSA) contributions can be changed/stopped at any time throughout the year without a QLE. Teammates can request a change by completing the eForm found on PeopleConnect > Human Resources > HR Forms > HSA Contribution Change Form or https://peopleconnectmore.carolinas.org/aspxapps/HSAContributionChange/
- Teammates have until April 30th of each year to submit Spending Account claims incurred during the prior plan year or during the grace period.
- If a teammate's employment ends or the teammate becomes ineligible for benefits due to a change in employment status, the teammate would no longer be eligible to participate in the FSAs for the remainder of the plan year. Any account balance remaining after the benefit termination date would be forfeited. Continuation of an FSA may be available through COBRA.

Questions or concerns? Contact the Benefits Support Center at **704.631.0263** or by email at **HRBenefitsOnline@AtriumHealth.org**.