Request to Change Flexible Benefit Elections

The Flexible Benefits elections made during an annual enrollment period are effective throughout the next plan year (January 1 through December 31). Between annual enrollments, you may be able to change your benefit coverage decisions ONLY if you have a "qualifying life event." Examples of qualifying life events include: birth or adoption of a child, change in marital status, death of a dependent, loss of coverage for you or your dependent under another program (i.e., spouse/partner had coverage with employer and ends employment). Under IRS regulations, the change must be requested within 30 days of the event and must be consistent with the qualifying life event that took place.

Name:____ SS# or LIN:________________________________

Campus Address:____

Extension:____________________________ Email Address:_____________________________

Describe Qualifying Life Event:____

____

Date of Qualifying Life Event:____________________ Effective Date of Change:___________________________

Please add or delete the following spouse/partner/dependent children:*

Name	Relationship	Date of Birth	Social Security #	Action
				☐ Add ☐ Delete
				☐ Add ☐ Delete
				☐ Add ☐ Delete
				☐ Add ☐ Delete
				☐ Add ☐ Delete

***You must provide proof of divorce, termination of partnership, or death to remove a spouse/partner or dependent child; you must provide a copy of official marriage documentation or partnership affidavit to add a spouse/partner; you must provide a birth certificate or adoption papers to add a dependent child to your benefits.**

*If you plan to cover your spouse/partner on one of Lehigh's medical coverage plans, check one of the following:

☐ My spouse/partner is not employed.

☐ My spouse/partner does not have access to employer sponsored medical coverage with his/her employer (where the employer pays at least 50 percent of the cost)

☐ My spouse/partner is enrolled in medical coverage at his or her employer and Lehigh's insurance will be secondary.

☐ My spouse/partner has access to employer sponsored medical coverage at his/her employer and is choosing not to participate. **Lehigh's insurance will be primary and I agree to pay an additional $75 per month for this coverage.**

(OVER)

Please approve the following benefit election changes based on the qualifying life event stated on the reverse side:

☐ *I currently have no medical coverage and would like to enroll in (check one):*

☐ CMM Plan ☐ PPO 80 ☐ PPO 100 ☐ Keystone HMO

You must complete an enrollment form.

☐ Medical Coverage – *I want to change who is covered to (you cannot change plans):*

☐ No Coverage ☐ EE Only ☐ EE & SP/Partner ☐ EE/Child ☐ EE/Family

You must complete an enrollment form.

☐ Dental Insurance – *I want to change who is covered to:*

☐ No Coverage ☐ EE Only ☐ EE + one ☐ EE + two or more

You must complete an enrollment form.

☐ Supplemental Life Insurance – *I want to change my coverage to (can only be increased one level above the previous year's life insurance without providing medical information and receiving approval from the insurance carrier.):*

☐ 100% of salary ☐ 200 % of salary ☐ 300% of salary ☐ 400% of salary

☐ Dependent Life Insurance – *I want to change my coverage to (check all that apply):*

General:	*Child:*	*Spouse/Partner:*
☐ No Coverage	☐ $ 5,000	☐ $10,000
☐ No Child Coverage	☐ $10,000	☐ $20,000
☐ No Spouse/Partner Coverage		☐ $30,000

Please note: Evidence of Insurability for any increase in spouse/partner life insurance is required.

☐ Long Term Disability Insurance – *I want to change premium taxation to:*

☐ Pre-tax ☐ Post-tax

☐ Flexible Spending Account(s) – *I want to change my annual goal amount to:*

☐ Health Care Account $__________ per ☐ month /☐ year (check one)

☐ Dependent Care Account $__________ per ☐ month /☐ year (check one)

Please note: This will completely replace your original election.

My signature below indicates that the information provided above is true and correct to the best of my knowledge. Upon approval, I authorize Lehigh University to reduce my pay in the amount required for the before-tax choices I have indicated above and/or to deduct from my pay the amount required for the after-tax choices I have indicated. I understand that any unused money contributed to my Flexible Spending Account(s) in excess of my reimbursable expenses is forfeited (IRS requirement). I understand that I will receive notification/confirmation of the denial/approval of my requested changes.

*Signature:*____ *Date:*________________________________

I would like to change my beneficiary. Please send the appropriate forms for:

☐ Pension ☐ Life Insurance

Human Resources Use Only:

☐ Approve ☐ Deny Initials:_____________ Date:___________________

Comments:____