

Western Maryland Health System Benefits Change Form

I am requesting a change to my FlexBenefits enrollment due to the following life status change as allowed under the Government Section 125 IRS regulation code. I am listing the information below for the following reason(s) which became effective on _____. I also understand that I can only make these changes within 31 days from the qualifying event.

- | | | |
|---|--|--|
| <input type="checkbox"/> Marriage (Marriage Cert. required) | <input type="checkbox"/> Divorce/ Legal Separation (Court Doc. required) | <input type="checkbox"/> Birth, adoption, or placement for adoption |
| <input type="checkbox"/> Death of spouse or dependent | <input type="checkbox"/> Change in spouse or dependent's employment | <input type="checkbox"/> Other (explain) _____ |
| <input type="checkbox"/> Covered dependent loss of eligibility (i.e. age) | <input type="checkbox"/> Change in spouse's eligibility for insurance | |
| <input type="checkbox"/> Dependent loss coverage under other plan | <input type="checkbox"/> Spouse's employer health plan terminated | <input type="checkbox"/> Hours increase – benefits are effective the 1st day of the 2 nd month following the hours change effective date. |

Please complete the following information for any eligible participants that you wish to add or delete from your insurance coverage.

* Benefits are effective the first day of the month after the effective date of the qualifying event for ADDS and effective the last day of the month for DELETES except for the birth or adoption of a child which are effective immediately or for Hours increase (see above).

____ ADD <input checked="" type="checkbox"/> X ____ DELETE		Full-time Student? Yes/No	OTHER INSURANCE YES/NO	PCP SILVER MED PLAN	Please indicate which plan you want your family member enrolled in or deleted from:					
NAME	SSN				SEX	DOB	Medical	Dental	Vision	AD&D

FROM	TO	FROM	TO
MED _____	_____	STD _____	_____
DENTAL _____	_____	LTD _____	_____
VISION _____	_____	AD&D _____	_____
SUPP LIFE _____	_____	SPENDING ACCTS: HEALTH CARE \$ _____	
		DEPENDENT CARE \$ _____	

BENEFICIARY CHANGE (OPTIONAL) Change Beneficiary Designations for Basic Life, Supplemental Life & AD&D Benefits to:

BENEFICIARY NAME _____ %	BENEFICIARY NAME _____ %
RELATIONSHIP _____ DOB _____	RELATIONSHIP _____ DOB _____

Authorization:
My signature below authorizes the change to my FlexBenefits enrollment and I understand that these changes may affect my biweekly payroll deduction from my paycheck. I also understand this is a pre-tax benefit and is governed by the IRS.

Signature

SSN

Date

02/09/2009
Benefits:flexbenefitschangeform