Human Resources
306 S. New Street, Suite 437, Bethlehem PA 18015-1687
Tel: (610) 758-3900 Fax: (610) 758-6226
Email: inben@lehigh.edu

2021 COVID-19 Request to Change Flexible Benefit Election

This form is to be used to request mid-year changes to your medical plan election under the Flexible Benefits Plan permitted through October 31, 2021 as a result of the COVID-19 pandemic; all other flexible benefit change requests, including changes to a Dependent Care FSA due to a qualifying life event (QLE) should be submitted as usual via the Lehigh Benefits website. For more information, see https://hr.lehigh.edu/benefits/QLE

Employee Name: **LIN:** **Date:**

Medical Plans – Section 1

Select one:		
☐ 1. I am currently enrolled in a medical plan and wish to change my election to a different plan. *(Please complete Option 1 below and Medical Plans – Section 2 on next page)*	☐ 2. I previously waived medical coverage and wish to enroll in a plan. *(Please complete Option 2 below and MedicalPlans – Section 2 on next page)*	☐ I am currently enrolled in medical coverage and wish to waive my coverage.

Option 1: I am currently enrolled in a medical plan and wish to change my election to a different plan**.** Please change my election to:

Medical Plan Options: *select one*			
☐ HDHP w/ HSA*	☐ PPO	☐ PPO Plus	☐ Keystone HMO

Option 2: I waived medical coverage previously, and wish to enroll in the following medical plan at the selected coverage level:

Medical Plan Options: *select one*			
☐ HDHP w/ HSA*	☐ PPO	☐ PPO Plus	☐ Keystone HMO
Coverage Level: *select one*			
☐ Individual	☐ Employee + Spouse/Partner	☐ Employee + Child(ren)	☐ Family

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Medical Plans - Section 2:

Please list the dependents you wish to cover on your medical plan (note: dependent verification may be required):	*If electing the HDHP/HSA, please indicate the annual amount you wish to contribute to the HSA:

Acknowledgements:

By signing and submitting this 2021 COVID-19 Request to Change Flexible Benefit Election Form, I hereby:

- Confirm all of the information is true and accurate to the best of my knowledge.
- Authorize Lehigh University to reduce my pay in the amount required for the choices I have indicated on this form.
- (If waiving medical coverage) Attest that I am enrolled in, or immediately will enroll in, one of the following types of coverage: (1) employer-sponsored health coverage through the employer of my spouse or parent; (2) individual health insurance coverage enrolled in through the Health Insurance Marketplace (also known as the Health Insurance Exchange); (3) Medicaid; (4) Medicare; (5) TRICARE; (6) Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); or (7) other coverage that provides comprehensive health benefits (for example, health insurance purchased directly from an insurance company or health insurance provided through a student health plan).
- Confirm I understand if these changes are approved, they will remain in effect through the end of the current plan year (through December 31, 2021) and I cannot retract these changes or make additional changes at a later date for this plan year. Additional changes may be made only with a qualifying life event or during the annual open enrollment period for the next plan year.

Employee Signature: **Date Signed:**

Please return the completed form via email to inben@lehigh.edu. A Human Resources representative will review your request and contact you if additional information is needed. You will receive a confirmation email once your request has been processed. All approved requests will become effective on the first day of the month after the request is received.