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: _____

* *If adding spouse/partner to a University medical plan, you will be automatically assessed a monthly Spouse/Partner surcharge. See below for details and waiver options.*

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.**

*** Spouse/Partner Medical Coverage Information**

If you have elected to cover your spouse/partner under a University medical plan, a $100 monthly spouse/partner surcharge will be added to your medical insurance premium each month. Your waiver to be excluded from this surcharge is not automatic — you must request it each year. A waiver is available only if one of the following is true:

- Your spouse/partner is not employed.
- Your spouse/partner does not have access to employer-sponsored medical coverage with his/her employer where the employer pays at least 50% of the premium cost.
- Your spouse/partner is enrolled in medical coverage at his/her current or former employer. Lehigh's insurance will be secondary for him/her.

Details about the spouse/partner surcharge can be found in the Flexible Benefits Enrollment and Reference Guide, under Benefits on the Human Resources home page. To determine if you qualify to have this charge waived, you must complete the Request for Waiver of Spouse/Partner Surcharge form. Spouse/partner surcharge amounts you pay before successfully completing the request cannot be refunded to you, even if the completed result confirms that you should not pay the surcharge going forward.

To qualify for a waiver of the spouse/partner surcharge, the Request for Waiver of Spouse/Partner Surcharge form MUST be received in Human Resources by either the 5th or the 20th of the month to avoid the waiver being applied to the next pay following the coverage change date.

(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: _____

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