Carolinas HealthCare System

Benefits Enrollment and Change Form

CHS LiveWELL Health Plan, HSA, Dental, Vision, FSA

Please use this form for mid-year changes in which you experience a Qualifying Life Event. Qualifying Life Events include:

- Loss or Gain of Coverage or Eligibility
- Change in Dependent Status or Eligibility

Please remember:

- Complete the highlighted sections
- Type or write legibly
- Submit only one form
- Incomplete forms cannot be processed

Name: _____ Teammate ID: _____

Email Address: _____ Phone Number: _____

Elect, Change or Cancel Coverage

IMPORTANT REMINDER: Supporting Documentation is required for any mid-year events. 1) Adding or Deleting Dependents: A separate request for documentation will come from The Dependent Verification Center within 30 days. 2) Loss or Addition of Coverage: For coverage changes due to a loss or addition of coverage, please submit a letter from the previous provider.

☐ Enroll
☐ Cancel
☐ Change of Coverage

Check the box that best describes the **reason for this action**:

☐ Loss/Gain of Spouse Group Coverage
☐ Loss/Gain of Coverage for Dependent Child
☐ Status Change

Effective Date of the Coverage Action: ____/____/____

Choose Your Plan(s)

Choose one option in each plan to either ELECT or WAIVE coverage for yourself and any eligible dependents.

Medical: ☐ Enroll ☐ Waive
Dental: ☐ Enroll ☐ Waive
Vision: ☐ Enroll ☐ Waive

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If you are enrolling in the CHS LiveWELL Health Plan, answer these required questions:

1. TOBACCO USER

A. Do you or any of your covered dependents (spouse or children) smoke or use tobacco products?

☐ Yes – Tobacco User Plan Rates may apply. Answer Question B

☐ No – Tobacco User Plan Rates will NOT apply. Skip to Question #2

B. Are all smoker/tobacco users that you have elected to cover participating in a Smoking/Tobacco Cessation Program?

☐ Yes – Tobacco User Plan Rates will NOT apply

☐ No – Tobacco User Plan Rates 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.

2. WORKING SPOUSE

A. Is your spouse eligible for group health benefit coverage through his/her employer?

☐ Yes – Please answer Question B

☐ No – Working Spouse Rate will NOT apply. Skip to the next section

B. Is your spouse also employed with Carolinas HealthCare System?

☐ No – The Working Spouse Rate will apply

☐ Yes – The Working Spouse Rate will NOT apply

Provide the Teammate ID for your spouse: _____

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Enroll Yourself and Your Dependents

Mark (+) to add to a plan or mark (-) to waive

Dependent Name	Birth Date	Relationship	Gender	Social Security Number	Medical +	Medical -	Dental +	Dental -	Vision +	Vision -
		SELF								

Contribute to Your Health Savings Account (HSA)

I authorize a 2017 bi-weekly contribution of $ _____ to be made to my Health Savings Account. 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 $3,400 for Teammate Only coverage or $6,750 for all other coverage levels for the plan year. An additional "catch up" contribution of $1,000 is permitted for teammates who will be age 55 or older any time during 2017.

Enroll in a Limited Purpose Flexible Spending Account

I authorize a 2017 bi-weekly contribution of $ _____ to be made to my Limited Purpose FSA Account. 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 $2,550 for the plan year.

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Enroll in a Dependent Care Flexible Spending Account

I authorize a 2017 bi-weekly contribution of $ _____ to be made to my Dependent Care FSA Account. 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.

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.

Enroll in a Health Care Flexible Spending Account (if not eligible for an HSA)

I authorize a 2017 bi-weekly contribution of $ _____ to be made to my Health Care FSA Account. 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 $2,550 for the plan year.

Acknowledgement

I have reviewed the written materials provided online at healthandretirement.carolinashealthcare.org provided to me describing the plans, and agree to the terms of participation set forth in written materials. 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 waived. I understand that I must provide documentation of eligibility for each dependent that I cover under the CHS LiveWELL Health Plan, Dental or Vision plans. This information will be requested via mail from The Dependent Verification Center.

_____ _____

Teammate Signature Date

Submit this completed and signed form to CHS Benefits Administration:

- Email as an attachment to hrbenefitsonline@carolinashealthcare.org
- Or, fax to 704-446-6623

ENROLL IN ADDITIONAL BENEFITS

You have 31 days from the day of your Qualifying Life Event to enroll in Additional Benefits. Please use the link provided below to enroll in Additional Benefits:

https://peopleconnectmore.carolinas.org/aspxapps/ssoBenefitFocus/Account/Login?ReturnUrl=%2faspxapps%2fssoBenefitFocus