Benefits Status Change Application

Instructions: To make a change to your benefit elections, outside of the regular enrollment period, complete this form and attach supporting documentation such as marriage certificate, birth certificate, divorce/adoption decree, insurance cancellation/COBRA notice, certification of an authorized placement agency or court judgment, decree or other order forms placing the child with you for adoption or foster care. Return this completed form and accompanying documentation to your Human Resources Representative as soon as possible **but within 30 days of the event**. By law, changes to election can only occur within the first 30 days of the event. Completion of this form does not guarantee approval. All changes in benefits are subject to federal regulations and underwriting requirements or limitations as stated in the Plan(s). Please refer to the Summary Plan Description for Plan details.

Employee Name:	EE ID:
Location:	

Description of Event: **Application must be submitted within 30 days of the actual event**. Only the events listed below may be considered when making changes to your elections. Please indicate below the change in family status or significant change that you are requesting a new election under the benefits program.

I have experienced the following event on the following date:_____/____/____

- ☐ Divorce/Legal Separation/Annulment
- ☐ Birth or Adoption of Child
- ☐ Marriage Includes Common LawUnion
- ☐ Dependent Child Attains Age 26
- ☐ Employment Status Change (i.e. union to union-free, begin or return from LOA)
- ☐ Child placed pending permanent adoption/or foster care
- ☐ HSA ElectionChange (Life event not required)
- ☐ Spousebegins employment
- ☐ You or Your Dependent Eligible for Coverage elsewhere
- ☐ Spouseseparates employment
- ☐ Qualified Medical Child Support Order
- ☐ Work Location Change from_____to _____
- ☐ Other _____

Documentation of your new dependent is required:

-Spouse: Marriage Certificate
-Child: Birth Certificate*

Please complete for adding or deleting coverage for yourself or your dependents

Add	Delete	Legal Name	**Social Security Number	Relationship to Employee (Self, Spouse, Child)	Date of Birth

Please indicate the changes to your elections. Note: changes made must be consistent with the reason for the change. Refer to the Summary Plan Description book for details.

* Acceptable documents for adding a newborn = official birth certificate **or** complimentary birth certificate provided by hospital.

** Social security number is required. If adding a newborn, leave blank and provide copy of social security card to HR when available

Important Additional Information

Item 1: Divorce/Legal Separation/Annulment/Dependent Loss of Coverage: Your spouse, ex-spouse, or dependents may be eligible for continuation of certain benefits. Please provide current address information specific to your spouse, ex-spouse, or dependents in order to notify them of their rights, if any, under our benefits plans.

Full name:_____ MailingAddress:_____
City:_____ State:_____ Zip:_____ Telephone: (_____)_____
Plan Year: The "Plan Year" is currently January 1-December 31. Any changes in election, approved by the Plan Administrator, will be effective on the date of the event unless otherwise noted. All new elections will remain in force until the earlier of 1) another qualified change in family status/significant change, 2) separation of employment/ineligible class, 3) the next Plan year.

Check Applicable Coverage	Employee Only	Employee/Spouse	Employee/Child(ren)	Family	Waive Coverage
Medical PPO					
Medical CDHP1					
Medical CDHP2					
Dental 1					
Dental 2					
Vision					
Limited Purpose FSA		Change Annual Election to $			
Dependent Care FSA		Change Annual Election to $			
HSA		Change Annual Election to $			
Have **YOU** used tobacco in the last 12 months?		**Yes** ☐ **No** ☐			
Has your **SPOUSE** used tobacco in the last 12 months?		**Yes** ☐ **No** ☐			
		Self $ Amount	**Spouse $ Amount**	**Child $ Amount**	**Waive Coverage**
Life Insurance					
Accident Insurance					
Critical Illness Insurance					
Parking FSA (Denver Only)		Change Monthly Election to $			

Note: Go to www.gateshealth.com, Important Links and click on the Life and AD&D link to update your life insurance beneficiary designation. Log on to Oracle Self Service to change your address, phone number, W-4 deductions, and emergency contact. See your HR Representative to change your marital status or name.

I understand a change in my election during the Plan Year is subject to the requirements of ERISA, the Internal Revenue Code, the terms of the underlying Plans, and the approval of the Plan Administrator. I certify that the above change in family status/significant change has occurred and the information provided to the best of my knowledge and belief, is correct and complete. I authorize the necessary payroll deductions to enforce the above elections.

Employee Signature:_____ **Date:**_____/_____/_____

HR Signature:_____ Processed Date: _____

Email completed form and verification documents to benefitssupport@gates.com