

QUALIFYING STATUS CHANGE

Return the completed form to your Benefits Counselor or HR Dept. Go to "Contacts" on Benefits Express if you are not familiar with the Benefits Counselor for your location.

Employee ID#: _____	Location: _____
Employee Name: _____	Social Security #: _____
Employee Phone # (Home): _____	(Work#): _____
Date reason became effective: _____	Reason Code (see below): _____
<p><i>To increase either of the following by one level:</i></p> <p>Life <input type="checkbox"/> AD&D <input type="checkbox"/></p>	
<p><i>To increase or decrease Dependent Life:</i></p> <p>Increase: <input type="checkbox"/> Decrease: <input type="checkbox"/></p>	
<p>Flexible Spending Accounts:</p> <p>Medical: <input type="checkbox"/> Dependent: <input type="checkbox"/></p> <p>Annual Amount: _____ Annual Amount: _____</p>	
<p>\$5,000/\$2,500 <input type="checkbox"/></p> <p>\$10,000/\$5,000 <input type="checkbox"/></p> <p>\$25,000/\$10,000 <input type="checkbox"/></p>	

1. (A = Add, D = Delete) coverage for following: 2. Indicate Option # ONLY if **adding** coverages for self.

Name	Birth Date	Social Security #	Rel.	Sex	Medical A/D Opt#	Dental A/D Opt#	Vision A/D
SELF	N/A	N/A	Self	N/A			
			Spouse		N/A	N/A	
			Child		N/A	N/A	
			Child		N/A	N/A	
			Child		N/A	N/A	

I authorize Main Line Health, Inc. to make before/after-tax deductions for the coverages I've indicated. I understand I cannot change these coverages until the next annual enrollment period, unless I have a qualifying change of status.

Employee Signature _____
Date:

Reference

- | | |
|---|---|
| <p>Reason Codes:</p> <ul style="list-style-type: none"> A. Marriage B. Divorce C. Death D. Birth/Adoption E. Gain/Loss of other coverage G. Change in Dependent Status of a child H. Hours Change | <p>Med Opt #:</p> <ul style="list-style-type: none"> 1. Waive 2. JeffPlus Aetna USHC PPO 3. JeffPlus Personal Choice PPO 4. JeffPlus Keystone HMO 5. JeffPlus Aetna USHC HMO 6. Aetna CDHP <p>Den Opt #:</p> <ul style="list-style-type: none"> 1. Waive 2. Prudential DMO 3. Delta Premier Dental |
|---|---|

Proof of Change: You must attach proof of change documentation for all reason codes including, benefits termination letter, marriage/birth cert., divorce decree.

Dependent Proof of Eligibility: If you are adding a dependent(s) to your coverage, you must attach documentation to this form that proves the dependent(s) is eligible for coverage under the MLH benefit plans. Acceptable proof of eligibility includes: valid marriage certificate when adding a spouse or birth certificate when adding a son or daughter.

Please contact your Benefit Counselor for a complete list of acceptable eligibility documentation.

- IMPORTANT - Please Read

1. This form must be returned within 30 days of the date your change occurred in order to change your benefit choices.
2. Your new coverages will become effective the first of the month following the day you return this form.
3. All changes are subject to restrictions, see back of form for restrictions.