2024 BENEFITS ELECTION CHANGE FORM

Use this form to change your benefit elections for the 2024 benefits plan year. Changes can only be made upon a Qualified Life Event and must be submitted to Human Resources within 30 days of that event per IRS regulations. Upon approval, **coverage will be effective the first day of the month following the life event.** A benefit confirmation statement will be sent to your email. Please review carefully and keep a copy for your records. Contributions shown below are on a per pay basis.

STEP 1: NAME:	**EMPLOYEE NO:**	**PHONE NUMBER:**	**Email:**

STEP 2: LIFE EVENT/STATUS CHANGE EFFECTIVE DATE: _____ REASON FOR CHANGE *(documentation of event required)*

❑ Add dependent *(marriage, birth, adoption)*	❑ Status Change (no documentation required)	❑ Other, please explain in below box:
❑ Drop dependent *(divorce, death, other coverage)*	❑ Loss of prior coverage	

STEP 3: MEDICAL COVERAGE (*does not include the SWG Wellness discount*, see chart below for discounts)

	CONSUMER-DRIVEN HEALTH PLAN (CDHP) WITH HSA			BASIC PPO			HIGH PPO		
COVERAGE LEVEL		**Full-time**	**Half-time**		**Full-time**	**Half-time**		**Full-time**	**Half-Time**
Employee	❑	$ 128.17	$ 136.53	❑	$ 161.32	$ 176.41	❑	$ 287.95	$ 329.90
Employee + Child	❑	$ 163.23	$ 180.13	❑	$ 198.92	$ 223.05	❑	$ 440.77	$ 520.63
*Employee + Spouse**	❑	$ 271.86	$ 292.00	❑	$ 314.61	$ 342.30	❑	$ 595.70	$ 683.97
Employee + Children	❑	$ 186.39	$ 210.66	❑	$ 214.75	$ 245.56	❑	$ 502.25	$ 602.36
*Family**	❑	$ 295.26	$ 321.26	❑	$ 341.15	$ 375.45	❑	$ 719.47	$ 838.72

HEALTH SAVING ACCOUNT (HSA): Employees enrolled in the CDHP will automatically have $0.01 deducted from their earnings on a per pay basis in order to receive the Southwest HSA contributions (Individual $500/Family $1,000) unless indicating that you are opting out of the HSA. You can elect to contribute more than $0.01 per pay up to the 2023 IRS maximum (Individual $4,150/Family $8,300). If age, 55 years or older, you can contribute an additional $1,000. I elect $_____ on a per pay basis.

❑ WAIVE MEDICAL COVERAGE ❑ NO CHANGE IN MEDICAL COVERAGE

NEW PLAN IN 2024!

MEDFLEX SELECT

COVERAGE LEVEL		**Full-time**	**Half-Time**
Employee	❑	$ 150.02	$ 164.06
Employee + Child	❑	$ 184.91	$ 207.44
*Employee + Spouse**	❑	$ 292.58	$ 318.34
Employee + Children	❑	$ 199.72	$ 228.37
*Family**	❑	$ 317.27	$ 349.17

SPOUSAL SURCHARGE

*A $225 monthly surcharge ($103.85 per pay) will be added to the above cost when your spouse has medical coverage available at this or her place of employment as acknowledged below. Falsification of this information may result in cancellation of medical coverage and corrective action up to and including dismissal. If your spouse's status changes throughout the year, you have 30 days from the date of the change to notify HR.

❑ I elect to enroll my spouse under my medical plan and he/she **DOES NOT HAVE OTHER COVERAGE AVAILABLE** through their employer. The spousal surcharge does not apply.

❑ I elect to enroll my spouse under my medical plan and he/she **HAS OTHER COVERAGE AVAILABLE THROUGH THEIR EMPLOYER. I ACCEPT THE $225 monthly ($103.85 per pay) SPOUSAL SURCHARGE.**

WELLNESS:

PATHWAY 1:
EMPLOYEE DISCOUNT PER PAY = $45 COVERED SPOUSE DISCOUNT PER PAY = $45
PATHWAY 2:
EMPLOYEE DISCOUNT PER PAY = $90 COVERED SPOUSE DISCOUNT PER PAY = $90

STEP 4: DENTAL ELECTION	CIGNA DENTAL PPO			CIGNA DENTAL HMO			**STEP 5: VSP VISION**		
COVERAGE LEVEL		**Full-time**	**Half-time**		**Full-time**	**Half-time**		**Full-time**	**Half-time**
Employee	❑	$ 9.22	$ 11.02	❑	$ 6.55	$ 7.68	❑	$2.76	$2.76
Employee + Dependent (Child or Spouse)	❑	$ 17.46	$ 20.83	❑	$ 12.71	$ 14.89	❑	$5.03	$5.03
Family	❑	$ 29.16	$ 35.45	❑	$ 18.41	$ 22.01	❑	$8.77	$8.77

❑ WAIVE DENTAL COVERAGE ❑ NO CHANGE IN DENTAL COVERAGE ❑ WAIVE VISION ❑ NO CHANGE

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STEP 6: VOLUNTARY EMPLOYEE		STEP 7: VOLUNTARY DEPENDENT		STEP 8: FLEXIBLE SPENDING ACCOUNTS (FSA)	
TERM LIFE	AD&D	TERM LIFE	AD&D	**HEALTH CARE FSA**	**LIMITED PURPOSE HEALTH CARE**
❑ Elect $_____ ❑ WAIVE ❑ NO CHANGE	❑ Elect $_____ ❑ WAIVE ❑ NO CHANGE	❑ Elect ❑ WAIVE ❑ NO CHANGE	❑ Elect ❑ WAIVE ❑ NO CHANGE	Eligible Basic/High PPO enrollees-limit $3,200) $_____ per pay	(Eligible for CDHP/HSA enrollees only-limit $3200) $_____ per pay
If electing coverage for the first time & were previously eligible, any amount is subject to Evidence of Insurability. If you currently have coverage, you may increase your benefit up to $500,000 in $10,000 increments. Increase >$50,000 require EOI.		*You must elect employee voluntary life prior to covering your dependent or you will automatically be enrolled for $10,000 in coverage for yourself.*		DEPENDENT CARE (limit $5,000) $_____ per pay (refer to Benefits Guide for more information on FSA)	

STEP 9: SHORT TERM DISABILITY – STD BUY UP PLAN (FOR FULL TIME EMPLOYEES ONLY)

STD BUY UP

❑ ELECT / ❑ WAIVE

All full-time employees receive short-term disability insurance that starts after you've been disabled for 14 days. You have the option to pay an additional premium to reduce that period to 7 days. The cost of the coverage is dependent on your annual salary. Buy Up STD will require Evidence of Insurability (EOI) if electing outside of the new hire or newly eligible benefit enrollment period.

The rates shown below give ballpark figures for the cost of this benefit. Rates are based on the full time employee's annual salary.

Base Annual Salary	$80,000	$70,000	$60,000	$50,000	$40,000
Monthly Buy Up Premium	$10.89	$9.53	$8.17	$6.81	$5.45
Per Pay Cost	***$5.03***	***$4.40***	***$3.77***	***$3.14***	***$2.51***

STEP 10: DEPENDENTS INFORMATION – *THIS SECTION MUST BE COMPLETE INCLUDING SSN FOR DEPENDENTS TO BE ACCEPTED*

Medical	Dental	Vision	Name (Last, First, MI)	Birthdate	Social Security Number	Sex	Relation
❑	❑	❑				M F	Spouse
❑	❑	❑				M F	Child
❑	❑	❑				M F	Child

SPOUSE	*Your legal spouse (not divorced or legally separated)*	*Marriage certificate **or** page one of your most recent tax return (cross out wage info)*
CHILDREN (Yours or your spouse's)	*Natural or legally adopted children under age 26*	*Birth certificate showing you or your spouse as the birth parent, birth & marriage certificate (if not natural born child), page one of your most recent tax return (cross out wage info.), or Custodial/Adoption/Legal Guardianship papers*
	Children under an official court-appointed guardianship who are under age 26	*When applicable court-issued Qualified Medical Child Support Order or divorce decree*
	Unmarried child, legally disabled and unable to earn a living regardless of age	*Disability Form*

STEP 11: I authorize Southwest Community Health System to deduct any necessary contributions from my salary to pay for the benefits I selected including deductions retroactive to the effective date of my benefits. Generally, health plan deductions are based on the pay date for coverage that month. I understand that all of these deductions will be taken in a single payroll. I understand that I cannot make changes to my elections unless I have a life-qualifying event or until the next annual enrollment. **I am also including all necessary proof for my eligible dependents or reason for the change. I am aware of the SWG Wellness program and understand that my results (or non-participation) will determine my medical plan contribution if I elected medical coverage.**

Employee Signature:_____ Date: _____

Farmers Select (Auto & Home) enrollment/changes can be made at any time by contacting 1-800-438-6388.

Southwest Matching Plan deferral changes can be made at any time by contacting Principal Financial Group at 1-800-547-7754 (Plan: 708952)