

Consolidated Communications
2024 QUALIFYING EVENT CHANGE FORM – CCI BIWEEKLY

Name _____

EE ID _____

Address (New? Yes No) _____

IMPORTANT: The documentation required for all events must be attached to this form and received within thirty-one days (31 days) of event.

Effective Date of Qualifying Event: _____

- Marriage (copy of Marriage License)
- Divorce (copy of pages in Divorce Decree that show date/parties)
- Birth or Adoption (copy of birth certificate or adoption papers)
- Death of covered dependent (copy of death certificate)
- Loss/Gain of other coverage (employee or eligible dependents; require documentation of change of insurance coverage)
- Change in employment status (employee or dependent; require proof of loss/gain of ins. coverage for dependent eligibility)
- Dependent meets or ceases to meet eligibility requirements (reaches max age limit for coverage: 26 years old)
- Other _____

I would like to make the following changes to my healthcare coverage:

HEALTH INSURANCE (includes Medical and Prescriptions): **WAIVE MEDICAL** _____

Election (check one)	Type of Coverage	Premium / Pay Period
BCBS Preferred Provider Option (PPO)		
<input type="checkbox"/>	Employee Only	\$ 105.46
<input type="checkbox"/>	Employee Plus Spouse	\$ 231.48
<input type="checkbox"/>	Employee Plus Child(ren)	\$ 208.34
<input type="checkbox"/>	Family	\$ 324.08
BCBS High Deductible Plan (HDP)¹		
<input type="checkbox"/>	Employee Only	\$ 59.46
<input type="checkbox"/>	Employee Plus Spouse	\$ 140.94
<input type="checkbox"/>	Employee Plus Child(ren)	\$ 126.84
<input type="checkbox"/>	Family	\$ 197.31
BCBS High Deductible Plan (LPHDP)¹		
<input type="checkbox"/>	Employee Only	\$ 28.07
<input type="checkbox"/>	Employee Plus Spouse	\$ 77.72
<input type="checkbox"/>	Employee Plus Child(ren)	\$ 69.95
<input type="checkbox"/>	Family	\$ 108.81
Kaiser HMO (CA Only)		
<input type="checkbox"/>	Employee Only	\$ 79.98
<input type="checkbox"/>	Employee Plus Spouse	\$ 183.96
<input type="checkbox"/>	Employee Plus Child(ren)	\$ 172.41
<input type="checkbox"/>	Family	\$ 271.05

If you completed the wellness program with Navigate, you will receive a credit of \$27.00 each pay period

DENTAL INSURANCE: **WAIVE DENTAL** _____

- Employee Only \$ 13.18
- Employee Plus Spouse \$ 25.57
- Employee Plus Child(ren) \$ 27.28
- Family Coverage \$ 40.19

VISION INSURANCE:

WAIVE VISION _____

- Employee Only \$ 1.90
- Employee Plus Spouse \$ 3.81
- Employee Plus Child(ren) \$ 4.07
- Family Coverage \$ 6.51

The following dependents and I will be covered under my health insurance plans:

If adding a new dependent, proof of dependent eligibility is required

Dependent's Name	Relationship	Plan	SSN	DOB	Sex	Add	Drop
		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				<input type="checkbox"/>	<input type="checkbox"/>

If dropping a dependent, please provide current address for Cobra eligibility: _____

¹ If enrolling in the HDP or LPHDP and wish to contribute to a savings account, please fill in your election on the worksheet listed below.

Health Savings Account (HSA) Contribution:

$\left(\begin{array}{c} \text{EE Annual} \\ \text{Pledge}^2 \end{array} - \begin{array}{c} \text{YTD} \\ \text{Contribution} \end{array} \right) / \begin{array}{c} \text{Remaining 2024} \\ \text{Pay Periods} \end{array} = \begin{array}{c} \text{Per Pay Period} \\ \text{Deduction} \end{array}$
<p>²Your Annual Pledge for 2024 cannot exceed \$4,150 for single coverage and \$8,300 for coverage with dependents. The Employee Annual Pledge does not include the employer HSA contribution. Employees 55 and older may make catch up contributions up to an additional \$1,000.</p>

I understand that any changes during the year to my healthcare coverage must be due to a qualified event as allowed for by Regulations under IRS Code Section 125. I understand that in order for this change to be effective on the event date, this form must be completed and returned to the Benefits Coordinator within 31 days of the change in status event and that the change I have requested must be consistent with the change in status event. I understand that if I wave my right to participate or fail to meet this deadline, my next opportunity to enroll or make changes will be during Open Enrollment or if I have another qualifying event. I understand I am responsible for paying the benefit premiums for each benefit, if applicable. I certify that the above information is true and correct, and agree to provide any necessary documentation to verify the change in status event.

Employee Signature

Date

If you elected Kaiser HMO, continue to page 3

If you are electing Kaiser HMO coverage, please read the following and sign below:

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signature Required for Kaiser Permanente HMO Plan

Date