Consolidated Communications

2024 Qualifying Event Change Form – CCI Weekly

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)	
☐	Employee Only	$ 48.67
☐	Employee Plus Spouse	$ 106.84
☐	Employee Plus Child(ren)	$ 96.16
☐	Family	$ 149.57
	BCBS High Deductible Plan (HDP)[1]	
☐	Employee Only	$ 27.44
☐	Employee Plus Spouse	$ 65.05
☐	Employee Plus Child(ren)	$ 58.54
☐	Family	$ 91.07
	BCBS High Deductible Plan (LPHDP)[1]	
☐	Employee Only	$ 12.95
☐	Employee Plus Spouse	$ 35.87
☐	Employee Plus Child(ren)	$ 32.28
☐	Family	$ 50.22

If you completed the wellness program with Navigate, you will receive a credit of $12.46 each pay period

DENTAL INSURANCE: **WAIVE DENTAL** _____

☐	Employee Only	$ 6.08
☐	Employee Plus Spouse	$ 11.80
☐	Employee Plus Child(ren)	$ 12.59
☐	Family Coverage	$ 18.55

VISION INSURANCE: **WAIVE VISION** _____

☐	Employee Only	$ 0.88
☐	Employee Plus Spouse	$ 1.76
☐	Employee Plus Child(ren)	$ 1.88
☐	Family Coverage	$ 3.00

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
		☐ Medical ☐ Dental ☐ Vision				☐	☐
		☐ Medical ☐ Dental ☐ Vision				☐	☐
		☐ Medical ☐ Dental ☐ Vision				☐	☐
		☐ Medical ☐ Dental ☐ Vision				☐	☐

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:

(EE Annual Pledge[2] _____ - YTD Contribution _____) / Remaining 2024 Pay Periods _____ = Per Pay Period Deduction _____

[2]Your 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.

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