Consolidated Communications

2024 QUALIFYING EVENT CHANGE FORM - NNE UNION

NAME _____ **EE ID** _____

ADDRESS (New? Yes ☐ No ☐) _____ **PHONE** _____

_____ **EMAIL** _____

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

Effective Date of Qualifying Event: _____

- ☐ Marriage (copy of Marriage License) ☐ Divorce (copy of Divorce Decree)
- ☐ Birth or Adoption (copy of birth certificate or adoption papers)
- ☐ Death of covered dependent (copy of death certificate)
- ☐ Loss/Gain of other coverage (For employee, spouse, or dependents; require documentation of change of insurance coverage)
- ☐ Change in employment status (employee or dependent; require documentation of loss/gain of insurance coverage for dependent eligibility)
- ☐ Dependent meets or ceases to meet eligibility requirements (reaches maximum age limit for coverage which is 26 years old)
- ☐ Other _____

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

Medical (includes dental & prescription):

FMCP	***Per Pay***
☐ Employee Only	$39.80
☐ Employee Plus Spouse	$75.51
☐ Employee Plus Child(ren)	$70.54
☐ Employee Plus Family	$104.79

Vision:

VSP	***Per Pay***
☐ Employee Only	$0.88
☐ Employee Plus Spouse	$1.76
☐ Employee Plus Child(ren)	$1.88
☐ Employee Plus Family	$3.00

- ☐ Waive Medical Coverage
- ☐ Waive Vision Coverage

Dependent Information: Need to also provide verification documentation

Dependent Name	SSN	Date of Birth	Relationship	Plan	Add	Drop
				MED/VIS	☐	☐
				MED/VIS	☐	☐
				MED/VIS	☐	☐

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

_____

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's Signature _____ **Date** _____