Wespath
BENEFITS | INVESTMENTS

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Choose one: ❑ New Enrollment ❑ Existing Enrollment

HealthFlex New Enrollment or Change Form

New hires and newly eligible participants must provide complete information on each eligible dependent. Enrolled participants making changes should provide only the information that has changed.

Part 1 – Participant/Plan Sponsor Information

Participant name _____ Participant # _____

Mailing address _____ Social Security # _____
(Last 5 numbers unless new enrollment)

_____ Primary phone # _____

E-mail address _____ Alternate phone # _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic Partnership[1]

Effective date of marital status _____

Conference/Plan Sponsor/Employer	Employer #	Date of Hire	Appointment/ Employment Status	Status Effective Date	Last Day Worked	Weekly Hours

3167/051121

Part 2 – Processing Event

Please check the processing event below. Event effective date _____

Life Status Event	Event Name	Life Status Event	Event Name
New Enrollment	❑ New hire ❑ Newly eligible ❑ New dependent ❑ Divorce ❑ Spousal death ❑ Spouse loses other coverage	Death	❑ Participant death ❑ Retiree death ❑ Dependent death
		Termination	❑ Declines coverage ❑ Non-payment ❑ Participant losing eligibility
Add Dependent for Covered Participants	❑ Dependent loses other coverage ❑ New dependent	Other	❑ Annual election ❑ Conference transfer ❑ Continuation ❑ Divorced spouse/legal decree ❑ New Retiree ❑ Regaining eligibility/same plan year ❑ Retiree to active ❑ No longer eligible for Medicare Secondary Payer Small Employer Exception (MSPSEE) ❑ Other _____
Delete Dependent for Covered Participants	❑ Dependent child ineligible ❑ Dependent gains other coverage ❑ Divorce		

Please list any special notes regarding the event:

_____

_____

_____

_____

Part 3 – Participant and Dependent Information

- List participant ***and*** all eligible dependents, including spouse[1], even if declining coverage. If participant is currently enrolled and adding/removing a dependent, list only that dependent's information.
- Indicate whether or not each individual will be covered. ***Important:*** *If you do not choose "yes" or "no" under the* ***Cover*** *column for each dependent listed, we will assume you* ***do not*** *want to cover that dependent(s) in HealthFlex.*
- Use **Part 8** to provide information on additional dependents.

Name	Social Security #	Birth Date	Relationship	Gender		Disabled		Cover					
								Medical		Dental		Vision	
				F	M	Yes	No	Yes	No	Yes	No	Yes	No

Part 4 – Elections (Active Employees and Pre-65 Retirees[2])

Medical/Pharmacy	Vision	Dental (if applicable)
❑ B1000	❑ Vision Exam Core	❑ Dental PPO
❑ C2000 with HRA	❑ Vision Full Service	❑ DHMO
❑ C3000 with HRA	❑ Vision Premier	❑ Dental Passive PPO 2000
❑ H1500 with HSA	❑ None	❑ None
❑ H2000 with HSA		
❑ H3000 with HSA		
❑ None*		

Notes:
- If no boxes are checked, any individuals who are covered in Part 3 will be enrolled in the default plans.
- Pharmacy, Exam Core vision (unless waived) and behavioral health coverage is included with every medical election.
- None*—If waiving HealthFlex coverage, Plan Sponsor must complete a *HealthFlex Mandatory Coverage Waiver Form*.

❑ Health Care Flexible Spending Account (FSA) (if applicable) $_____ *(annual amount)*
❑ Dependent Care FSA (if applicable) $_____ *(annual amount)*
❑ Health Savings Account (HSA) personal contribution (if applicable/eligible) $_____ *(prorated annual amount[3])*

- To enroll into a HSA and to receive the HSA plan sponsor contribution and/or make personal contributions to the HSA, participant must attest to the following:
  - ❑ I have read, understand, and accept the eligibility rules of a Health Savings Account (HSA) and I confirm that I am eligible for an HSA.
  - ❑ I have read, understand, and accept the HealthEquity Terms of Use, the Card Holder Agreement and Custodial Agreement.
- To change the current HSA contribution, enter the new amount[4] here: $_____
- To decline the HSA, participant must check the statement below:
  - ❑ Although I have elected an HSA Plan, I elect to waive the HSA. By waiving the HSA, I acknowledge that I will not receive the HSA plan sponsor contribution and I will not be able to make personal contributions into an HSA.

Part 5 – Declination of Coverage Information for Participants

If you are declining to cover yourself or any eligible dependents, it is important you understand certain plan rules. By declining coverage, you are declining coverage for the balance of the current plan year, and all subsequent plan years unless you enroll for such coverage during a subsequent annual election period for coverage commencing on the following January 1. Also, any persons for whom coverage is being declined will be subject to late entrant provisions under the plans. In certain circumstances, you may be able to enroll for coverage for yourself or eligible dependents prior to a subsequent annual election period. These circumstances include marriage, birth, adoption or legal guardianship, or loss of other health insurance as provided under the Health Insurance Portability and Accountability Act of 1996 and change of status rules under HealthFlex.

Please make sure to check with your Plan Sponsor regarding the consequences and rules for declining health coverage as a retired participant.

Part 6 – Participant Signature

I attest that the participant information is true to the best of my knowledge. In addition, if I am an active participant, I have received, read and I understand the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Special Enrollment and Change of Status Event Provisions and the HealthFlex Notice of Privacy Practices, which are included in my New-Hire Enrollment Kit.

If I am declining coverage, I hereby acknowledge I read, understand and accept the rules listed in Part 5 of this form.

If I am an actively employed participant, I authorize my Salary-Paying Unit to make the appropriate pre-tax payroll deductions from my wages to apply toward my HealthFlex required contributions, if applicable.

Participant signature _____ Date _____

Part 7 – Plan Sponsor Authorization

Plan sponsor signature _____ Date _____

Part 8 – Additional Dependents

Name	Social Security #	Birth Date	Relationship	Gender		Disabled		Cover					
								Medical		Dental		Vision	
				F	M	Yes	No	Yes	No	Yes	No	Yes	No

Note: You can access a *Summary of Benefits and Coverage (SBC)*, which summarizes important information about any health coverage option offered by your plan sponsor. The SBC is available at **benefitsaccess.org**; log in and select the **Health** tab across the top, then select **Plan Details** to access the Benefitsolver website. You may need to complete a registration step the first time you use the link. Under the **Reference Center**, select **Summary of Benefits and Coverage (SBC)**. A paper copy is also available, free of charge, by calling **1-800-851-2201**.

[1] This applies to same-sex civil union partners or legal domestic partners of lay employees in states that have established civil unions or comprehensive state domestic partnerships if the plan sponsor has elected to provide such coverage through Exhibit D to its adoption agreement.

[2] Pre-65 retirees are not eligible to contribute to a Health Care FSA and/or Dependent Care FSA. In addition, they cannot make personal pre-tax contributions to a Health Savings Account.

[3] This amount does not include the HSA plan sponsor contribution or any excess defined contribution that will be added to the HSA. Please keep this in mind to avoid exceeding the HSA Annual Contribution Limit established by the Internal Revenue Service (IRS).

[4] This amount can not be less than what you have contributed to date through HealthFlex. In addition, this amount will be prorated and billed based on the number of months remaining in the plan year.