Benefit Plan Administrators – 2021 Change Form

Diocese of La Crosse Lay Group

Please Submit Within 30 Days of the Change or Qualifying Event

Effective Date of Change:

Employee Name: _____ **Member ID #:** _____

Parish / Institution: _____ **#** _____ GROUP #: 8201

Type of Change: ☐ Name Change ☐ Deletion of Dependents ☐ Addition of Dependents ☐ Address Change
☐ Deductible Change (Open/special enrollment only*) ☐ Other (see below)

Reason for Change: ☐ Birth, Adoption or Adoption Placement (date: _____) ☐ Loss of Other Insurance (date of loss: _____)
☐ Marriage (date: _____) ☐ Don't Need/Want ☐ Open Enrollment (Dec only) ☐ Other (see below)

☐ Name: Previous Name: _____ New Name: _____

☐ Address: Old: _____
Street City State Zip

New: _____
Street City State Zip

☐ Addition of Dependent(s): ☐ If additional space is needed, check here and continue on back of form.

Name: _____ Date of Birth: _____ SSN: _____ Relationship: _____

Name: _____ Date of Birth: _____ SSN: _____ Relationship: _____

For marriage or loss of other coverage, coverage may become effective either the date of the event or the first of the month following the event.
For birth, adoption or placement for adoption, coverage will become effective as of the date of birth, adoption or placement for adoption.

☐ Coverage

Current:	**Change To:**	**Cancel:**	**Deductible Change***
☐ Employee Medical	☐ Employee Medical	☐ Employee Medical	☐ to Traditional Plan
☐ Family Medical	☐ Family Medical	☐ Family Medical	☐ to HDHP / HSA Plan
☐ Employee Vision	☐ Employee Vision	☐ Employee Vision	
☐ Family Vision	☐ Family Vision	☐ Family Vision	
☐ Employee Dental	☐ Employee Dental	☐ Employee Dental	
☐ Employee + 1 Dental	☐ Employee + 1 Dental	☐ Employee + 1 Dental	
☐ Family Dental	☐ Family Dental	☐ Family Dental	
☐ Life Insurance	☐ Life Insurance	☐ Life Insurance	

NOTE: If you have your premiums deducted pre-tax under a cafeteria plan, you may only change or drop coverage mid-year of the cafeteria plan year with a qualifying event. ☐ My premiums are deducted pre-tax ☐ My premiums are not deducted pre-tax

☐ Other: _____

☐ Please Indicate Effective Date of Above Changes: _____

☐ Loss of Coverage: (***NOTE: If due to illness, please contact St. Ambrose Financial Services, Inc.)***

EMPLOYEE

☐ Termination – Last Day of Work _____

☐ Reduction of Hours – Last Day of Eligible Hours _____

DEPENDENT

☐ Death of Covered Employee – Date of Death _____

☐ Divorce or Legal Separation – Date of Divorce/Separation _____

☐ Employee's Entitlement to Medicare – Date of Entitlement _____

☐ Child's Loss of Dependent Status – Last Day of School/Loss of Status _____

I, the undersigned, an employee of the above-named policy holder, hereby certify that I have been given an opportunity to participate in benefits offered by my employer and after careful consideration, I hereby waive/cancel my right to:

☐ Life/AD&D ☐ Employee Medical ☐ Family Medical ☐ Employee Vision ☐ Family Vision
☐ Employee Dental ☐ EE + 1 Dep Dental ☐ Family Dental

Reason for waiving coverage: _____

I understand that if I waive/cancel my coverage at this time, I may only re-enroll as provided under the Special and Open Enrollment section of the plan document, and such a request must be made within 31 days of the qualifying event. I understand that evidence of insurability may be requested for life insurance if I apply at a later date and the carrier reserves the right to reject such applications.

_____ _____
Signature of Employee (or Employer for Terminations) Date Signed

Send Original Form To: **St. Ambrose Financial Services, Inc.**
P.O. Box 4004
La Crosse, WI 54602-4004
Phone: (608) 791-2669
Fax: (608) 787-8068

NOTE: Legally, the "Notice of Special Enrollment Period Rights" **MUST** be attached to this Change Form.

Rev. 11/2020

NOTICE OF SPECIAL ENROLLMENT PERIOD RIGHTS

I am aware that if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I have other coverage, I may later apply for coverage for me and/or my dependents if eligibility is lost under that other coverage, if the employer stops contributing toward the other coverage, or if adding a dependent due to marriage, birth, adoption or placement for adoption. Loss of eligibility may result from one of the following:

1. My spouse loses coverage due to job termination or has a reduction in hours to a status that is ineligible for coverage;
2. My spouse and I divorce;
3. My spouse dies; or
4. The expiration of COBRA for a previous employer.

I am aware that if I refuse coverage for myself and/or my dependents (including my spouse) when first eligible because I do not want coverage for whatever reason, I may later apply for coverage for myself and/or my dependents with:

1. Marriage; or
2. The birth, adoption or placement for adoption of a child.

In addition, you may add a new dependent to your plan as a result of a marriage, birth, adoption or placement for adoption. Application to add a new dependent must be made within 31 days of the event.

If you qualify for enrollment under any of the above exceptions you must complete and return the signed application to your employer or St. Ambrose Financial Services, Inc. within 31 days of the qualifying event. When adding a dependent to your existing policy, you must complete and return a signed change form to your employer or St. Ambrose Financial Services, Inc. within 30 days of the marriage, birth, adoption or placement for adoption.

You may also apply for coverage during the open enrollment period each year.

If you have any questions regarding special enrollment period rights, please feel free to contact Benefit Plan Administrators of Eau Claire Inc. at 1-800-236-7789.

AGE LIMITS FOR DEPENDENT CHILDREN

Coverage for eligible children will cease at the end of the month in which the child reaches the age of 26.

If you have any questions about whether particular enrollment changes would be eligible, please contact St. Ambrose Financial Services at 608-791-2669.