



2023 QUALIFYING LIFE EVENT FORM

ATTENTION: HR must receive this Qualifying Life Event (QLE) form within 31 days* of the event. Employees are encouraged to report QLEs prior to 31 days for the earliest possible effective date. Changes will be effective the first day of the month following submission of this form. (exception: birth & adoption will be effective the date of event).

Submit To: Hendrick Health Human Resources | Benefits (see page 3)

Employee # Employee Name Job Title DOB Preferred Phone

New Mailing Address? Yes No City State Zip Code Preferred Email

ENROLLMENT INFORMATION - Please Select Life Event Below (*See page 3 for documentation needed for each event)
Date of Qualifying Life Event:
Marriage Birth or Adoption of Child Employee gains other coverage Dependent gains other coverage
Divorce Death of Spouse or Child Employee loses other coverage Dependent loses other coverage
If divorce, address of ex-spouse: Other:

INDICATE CHANGES ONLY*

Pre-tax Options- Premiums will be deducted on a bi-weekly basis.
Baylor Scott & White Health Plan - Premiums do not include wellness discounts or tobacco surcharges.**
Plan Election: Hendrick HDHP Hendrick EPO OR Cancel Coverage
If electing new coverage, please check one Plan Election box above. If revising existing coverage, Plan Election will remain the same.
If electing new coverage, please check the box(es) below to indicate tobacco status. For information about the tobacco surcharge, including reasonable alternatives, refer to the Benefits Guide.
Tobacco Status: Employee - I have or have not used tobacco products in the past 12 months. Spouse: My spouse has or has not used tobacco products in the past 12 months. Default option if this step is skipped - Tobacco User.
Salary Range Up To \$15.00/hr Salary Range \$15.01 to \$30.00/hr Salary Range \$30.01 to \$45.00/hr Salary Range \$45.01/hr & Up
Metlife Dental
Plan Election: Low High OR Cancel Coverage
Superior Vision Cancel Coverage

*You have 31 days to notify Hendrick Health Human Resources | Benefits, unless you are entitled to additional time under federal policy or program.

Flexible Spending Accounts – Annual Maximum \$2,850

Election: Health Care Flexible Spending Account Limited Use Flexible Spending Account

New Annual Contribution \$ _____

Contributions not used within the plan year will be forfeited excluding a \$570 rollover.

Health Savings Account – Annual Maximum \$3,850 (single)/\$7,750 (family) (+\$1,000 if age 55+)

New Annual Contribution \$ _____

Contributions not used within the plan year will rollover year to year.

After Tax Options – Premiums will be deducted on a bi-weekly basis.

The Lincoln National Life Insurance Company

Group ID: HENDRICKHE

Optional Employee Life Cancel Coverage

Optional Spouse Life Cancel Coverage

New Election? If yes, indicate smoker status and coverage amount desired. Smoker Non-Smoker

Coverage Amount desired \$ _____ (GI Limit = \$25,000; EOI required for amount exceeding GI Limit)

(\$5,000 increments; maximum coverage amount = lesser of \$500,000 or 100% of Employee’s Optional Life Benefit)

Optional Child Life Cancel Coverage New Election: Child(ren) - \$0.92 (coverage = \$10,000 for each eligible child)

Disability Coverage **Short-Term Disability** Cancel Coverage **Long-Term Disability** Cancel Coverage

Accident Coverage Cancel Coverage

Employee Only- \$4.07 Employee + Spouse- \$6.65 Employee + Child(ren)-\$7.14 Employee + Family- \$9.70

Hospital Indemnity Cancel Coverage

Employee Only- \$6.71 Employee + Spouse- \$14.54 Employee + Child(ren)-\$10.44 Employee + Family- \$19.06

Critical Illness Cancel Employee Coverage Cancel Spouse Coverage

(Children are automatically covered free of charge if employee is currently enrolled at 25% of Employees policy amount)

(Spouse coverage amounts= \$5,000, \$10,000, or \$15,000 not to exceed 100% of Employee’s Critical Illness coverage)

Add Spouse Spouse Coverage Amount: \$ _____

Additional Voluntary Benefits

Trustmark Universal Life Insurance Cancel Employee Coverage Cancel Spouse Coverage Cancel Child(ren) Coverage

LifeLock Identity Theft Protection Cancel Coverage

When revising existing coverage, Plan Election will remain the same.

Employee Only Employee + Family (One or more family members)

Essential \$3.46 / Premier \$5.53

Essential \$6.92 / Premier \$11.07

ARAG Legal Insurance Cancel Coverage

Only list NEWLY enrolled dependent(s) below:

First Name, MI, Last	Social Security Number	Date of Birth	Gender	Relation	Disabled	Coverage Elected (Circle)	
						Medical	Dental
						Vision	Other
						Medical	Dental
						Vision	Other
						Medical	Dental
						Vision	Other
						Medical	Dental
						Vision	Other

If your dependent child(ren)’s address differs from your own, please indicate below.

Name(s) and Address: _____

Employee Authorization

I have received, read and understand benefit notices; including, but not limited to: the Summary of Benefits and Coverage (SBC), Medicare Part D Credible Coverage, Plan Document(s), and the Cafeteria Plan Document explaining the health plan. I understand all benefit notices are housed on the Human Resources Benefits page on the Hendrick Hub and in Performance Manager (paper copies provided upon request). I understand that by signing and submitting this form, I am making an election concerning my benefits for the enrollment period through December 31st. This election is binding subject to my right to make changes according to provisions of the program and subject to any changes required to comply with federal tax laws.

By signing this form, I authorize Hendrick to inform appropriate insurance carriers of my election enrollment(s) and/or change(s). I verify that the information on this form is true and correct.

Employee's Signature: _____

Date: _____

REQUIRED DOCUMENTATION

QUALIFYING LIFE EVENT VERIFICATION DOCUMENTS

Event Type	Document(s) Typically Required
Marriage**	Marriage Certificate
Birth	Birth Certificate(s)
Adoption	Signed Court Paperwork
Gain of Coverage	Document showing gain of coverage (must show name(s), effective date, and coverage type)
Loss of Coverage	Document showing loss of coverage (must show name(s) and effective date, and coverage type)*
Divorce (removing newly ineligible dependents)**	Signed Divorce Decree
Death**	Death Certificate

*Additional documents are required to verify dependent eligibility if covering spouse and/or child(ren)

**Information regarding beneficiary changes, can be found on the Human Resources page of the Hendrick Hub.

DEPENDENT VERIFICATION DOCUMENTS

Dependent Type	Dependent Eligibility Document(s) Required
Legal Spouse	-Marriage Certificate AND Tax Return issued within last two years (submit first page through signature line: mark out any financial information and first five digits of SSNs) OR -Marriage Certificate and proof of joint ownership issued with last six months OR -Marriage Certificate (if married within the last twelve months)
Informal, Common-Law Spouse	-Notarized Affidavit of Marriage or Declaration of Informal Marriage AND Tax Return issued within last two years (submit first page through signature line: mark out any financial information and first five digits of SSNs) OR proof of joint ownership issued within last six months
Biological Child	-Birth Certificate
Stepchild	-Birth Certificate and spouse eligibility document(s) – see above
Adopted or Foster Child	-Signed Court Paperwork

SUBMIT TO:

Hendrick Health Human Resources | Benefits

Scan and upload to Hendrick.Health/employeebenefits

Questions? Email benefits@hendrickhealth.org or call 325-670-3163

