MARICOPA COMMUNITY COLLEGES®

FLEX BENEFITS CHANGE REQUEST FORM

RETURN TO: MCCCD Employee Benefits Office
2411 W. 14th Street, Tempe, AZ 85281
Phone: (480) 731-8415 Fax: (480) 731-8484

Employee Name_____ **Employee ID Number**_____

College or Location	**Telephone Number (Work)**	**Telephone Number (Home)**

NOTE: Based on IRS regulations governing cafeteria benefit plans, changes in your Flex Benefit selections after your initial hire or outside of the open enrollment period are restricted to changes that result from a change in family status.

INSTRUCTIONS: Indicate below the reason you are requesting a change to your benefits. Please indicate all changes you are requesting on the MCCCD Benefits Enrollment Form located on page two (2) of this document. **Social Security #'s or qualified alternate ID #'s are required for all dependents. Documentation must be provided for any family status change, i.e. legal certification, death certificate or COBRA notification.** Examples of acceptable documentation can be found on page five (5) of this document.

Change of Status Deadlines:

If you make a request for a change in benefits due to a qualifying change of status event, your change in benefits will become effective the first of the month following the latest of:

1) The date of the qualifying event
2) The effective date of your personal benefits; or
3) The receipt of completed paperwork and all required documentation by the MCCCD Employee Benefits Department

The change of family status form, with the required documentation, must be received in the MCCCD Benefits Department within thirty (30) days from the date the qualifying event takes place.

Note: Changes between plans such as the Buy-Up to Core Medical and/or PPO to Prepaid dental may only be changed during the annual Open Enrollment period for health insurance.

Effective date ***(first day of the month following the date the change occurred)*** _____

Reason for change ***(must result from a change in family status):***

	CHANGE	DATE		CHANGE	DATE
	Birth/Adoption of Child			**Spouse's/Partner's loss of insurance**	
	Spouse's/Partner's commencement or termination of employment			**Death of Spouse, Partner or Dependent Child **Name of dependent:**	
	Marriage/Partnership			**Divorce/Dissolution of Partnership**	
	Other (Please explain)				

For examples of qualifying events see:
http://www.maricopa.edu/employees/divisions/hr/files/benefits/benefit.change.of.status.chart.2-1-1.pdf

I authorize MCCCD to use or disclose information contained on this form for purposes of treatment, payment or health care operations as specified under applicable law.

_____ _____

Employee Signature **Date**

ALL FORMS MUST BE FILED IN THE BENEFITS OFFICE WITHIN THE THIRTY-DAY LIMIT

MARICOPA COMMUNITY COLLEGES
Benefits Enrollment Form

Office Use Only

☐ New Employee
☐ Change of Status
Ben. Prog. _____
Effective Date _____

The following form must be completed in full in order to enroll in MCCCD insurance. Please indicate your choices by marking the ☐ next to your election. If any information changes, you must complete a new form within thirty (30) days of the date the change occurs.

EMPLOYEE INFORMATION

Name (last, first, MI)	Social Security Number	Employee ID Number	Service Date (mm,dd,yy)

Address (street) (city) (state) (zip code)	Occupation

☐ Male ☐ Female	☐ Married ☐ Single	Date of Birth (mm,dd,yy)	Home Phone	Work Phone	College

MEDICAL (Please select a Medical Plan & Coverage Level)

☐ **Core Plan** ☐ **Buy-Up Plan**

☐ Employee Only
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ Employee and Family
☐ Waive Coverage

Domestic Partner Coverage
☐ Employee & Domestic Partner (12)
☐ Family with Domestic Partner (14)

Dental (Please select a Dental Plan & Coverage Level)

☐ **PDP-MetLife** ☐ **Copay Opt 2-MetLife** ☐ **Prepaid-Assurant**

☐ Employee Only
☐ Employee and Spouse
☐ Employee and Child(ren)
☐ Employee and Family
☐ Waive Coverage

Domestic Partner Coverage
☐ Employee & Domestic Partner (12)
☐ Family with Domestic Partner (14)

DEPENDENT INFORMATION (Please list all dependents, spouse and/or child(ren), to be covered on your plan.)

First Name MI Last	Sex	Social Security Number	Date of Birth	Disabled (Y / N)	If enrolled in Medicare, indicate Medicare HICN
(Spouse/Domestic Partner)					
(Child)					
(Child)					
(Child)					
(Child)					
(Domestic Partner's Child)					
(Domestic Partner's Child)					

LIFE INSURANCE

☐ **Supplemental Term Life** (21)
Amount Elected $ _____ EofI Amt. $ _____

☐ **Dependent Term Life** (25)
Amount Elected $ _____ EofI Amt. $ _____

AD&PL

☐ **Employee Only AD/PL** (27)
Amount Elected $ _____

☐ **Family AD/PL** (24)
Amount Elected $ _____

SHORT-TERM DISABILITY

☐ **Short-Term Disability** (2Y)
Amount Elected $ _____
Annual Salary $ _____
EofI Amount $ _____

BENEFICIARIES (Your beneficiary designation applies to the $20,000 Basic Life, $15,000 Basic AD&D, as well as Supplemental Life and Supplement AD&PL, if applicable.)

Name	Address	Relationship	Social Security #	Birth Date	%	Primary Y / N

CERTIFICATION AND AUTHORIZATION

I acknowledge by signing this form that the information provided is true and correct to the best of my knowledge. I am applying for group benefits under MCCCD. I authorize pre-tax payroll deductions, as appropriate, for the costs of the coverage I have elected unless I have checked the box below requesting after-tax deductions. **Benefits paid for on a pre-tax basis are not eligible as deductions for tax purposes.** I understand that omissions or misstatements may be cause for rejection of claims or denial of benefits. Insurance fraud is generally defined as the "intentional misrepresentation of material facts and circumstances to an insurance company to obtain payment that would not otherwise be made." It is fraudulent to fail to notify the Benefits office of a change in status or to misrepresent dependents in any manner. Disciplinary action will be taken, up to and including termination, should this occur. I authorize and direct any group insurance carrier or health plan whose coverage is primary to the medical plan I have elected to pay hospital and medical benefits directly to the provider of service, if applicable. I further authorize any physician or medical facility to release medical information pertaining to my dependents and I to Meritain Health. **I authorize MCCCD to use or disclose information contained on this form for purposes of treatment, payment or health care operations as specified under applicable law.**

☐ Most benefit deductions are automatically made on a pre-tax basis, however, I wish to have all payroll deduction made on an after-tax basis

EMPLOYEE SIGNATURE _____ **DATE** _____

BENEFIT ENROLLMENT FORM INSTRUCTIONS and IMPORTANT INFORMATION

Use this form to select your voluntary MCCCD Flex Benefits. You may elect one level of coverage from each of the benefit categories. The dollar amount in parentheses in your Employee Benefits Rate Schedule will be your monthly cost. Please refer to the Employee Benefits web site for detailed information about these and other benefits. New hire elections take effect on the first of the month 30 days following the later of either your Board approved service date or start date. All new hire elections must be made within 30 days of your initial hire date. The benefit plan year ends on June 30. The benefits you elect will remain in force for the entire plan year unless you experience a qualified change of status event as defined under the Plan and in accordance with federal Internal Revenue Code regulations. MCCCD's medical plan applies a pre-existing condition limitation (does not apply to Buy-Up Plan in-network services). Individuals who enroll for medical plan coverage may need to show proof of other coverage (HIPAA certificate of creditable coverage) to avoid a pre-existing condition limitation in the medical plan. Employee Benefits web site address: http://www.maricopa.edu/employees/divisions/hr/benefits/index

MEDICAL INSURANCE

Medical insurance for employees is required. You may elect medical coverage for you, for you and your child(ren), for you and your spouse, or for you and your family. The coverage level you elect will apply to both the medical and prescription plans. You may be allowed to waive medical coverage if you are covered under another employer's group medical plan. Waiver eligibility requirements are available on the Employee Benefits web site. Premiums for medical insurance are deducted on a pre- tax basis.

DENTAL INSURANCE

Dental insurance for you and your family is optional. Premiums for dental insurance are deducted on a pre-tax basis.

SUPPLEMENTAL TERM LIFE INSURANCE

Supplemental employee life insurance is voluntary and subject to meeting eligibility through the insurance carrier. The amount you elect adds additional coverage to the $20,000 basic life insurance provided by MCCCD. You can calculate your supplemental life premium using the rate table provided below. Before you choose a coverage level and determine your cost, please take note of the following points:

- New Hires: May elect up to $150,000 of supplemental life coverage without Evidence of Insurability.
- New Hires: Who want to elect additional supplemental life insurance above $150,000, must complete Evidence of Insurability forms.
- Open Enrollment changes: Any amount elected requires Evidence of Insurability.
- Premiums for supplemental term life insurance in excess of $30,000 will be deducted on a post-tax basis per IRS regulations.

Monthly Premium Calculation for Life Insurance:
The monthly cost for your supplemental life insurance is based on the amount of coverage you elect and your age as of the date your coverage begins. Follow these steps to calculate your monthly life insurance premium:

1. Enter your age (as of the date the coverage begins) on line ① below.
2. Choose your desired coverage amount from the Employee Benefits Rate Schedule and write the amount on line ② below.
3. Determine the number of "units" of coverage by dividing your coverage amount by $1,000—for example, $35,000 divided by $1,000 equals 35 units—then enter the number of units on line ③.
4. From the rate chart below, enter the rate for your age category on line ④.
5. Multiply the monthly rate by the number of units and enter your cost on line ⑤.

Employee Age Category	Monthly Rates Per unit
<25	0.037
25-29	0.039
30-34	0.051
35-39	0.066
40-44	0.092
45-49	0.138
50-54	0.212
55-59	0.366
60-64	0.455
65-69	0.630
70-74	0.875
75-79	1.214
80-99	1.488

Employee Age	Coverage Amount	Number of Units		Rate Per Unit (from chart)		Monthly Premium
①	②	③	x	④	=	⑤
Example:						
52	$35,000	35	x	$0.212	=	$7.42

DEPENDENT TERM LIFE INSURANCE

Term life insurance for your dependents is voluntary and subject to meeting eligibility through the insurance carrier.

- New Hires: May elect up to $25,000 of Dependent Life Insurance coverage without Evidence of Insurability.
- Open Enrollment changes: Any amount elected requires Evidence of Insurability.
- Premiums for dependent life insurance will be deducted on an after-tax basis.

ACCIDENTAL DEATH AND PERSONAL LOSS (AD&PL) INSURANCE

AD&PL insurance for you or for you and your family is optional.

- AD&PL insurance may not exceed ten (10) times your annual base earnings if you enroll for an amount in excess of $150,000.
- Premiums for AD&PL insurance are deducted on a pre-tax basis.

SHORT-TERM DISABILITY INSURANCE

Short-term disability insurance for employees is voluntary and subject to meeting eligibility through the insurance carrier.

- The benefit level elected may not exceed two-thirds of your base salary.
- New Hires: May elect up to $1,450 of coverage (not to exceed two-thirds of your base salary) without Evidence of Insurability.
- Open Enrollment changes: If you are already participating in the short-term disability program, you may increase your elected amount one step as your salary allows. Any amount elected above one step will require Evidence of Insurability. Any amount added for the first time will require Evidence of Insurability.
- Premiums for short-term disability insurance are deducted on a pre-tax basis.

SIGNATURE AND DATE

Be sure to print sign and date this form. Please keep a copy for your records. Submit the original to MCCCD Employee Benefits Department, 2411 W. 14th Street, Tempe, AZ 85281-6942 prior to your benefit effective date.

Meritain Health Welcomes You! We are asking for your help in getting information on other Medical insurance coverage currently in effect for you or your dependents. This information will expedite claims processing and enhance your level of service. ***If we do not receive this information, it will delay the processing and payment of your claims.***

Please print:

Employee Name: _____

Employee Identification Number: _____

Name of Company (your employer): Maricopa County Community College District

Policy number (if known): 14450

Employee Signature & Date: _____

Do you or any of your dependents have other coverage in effect at this time?

Medical:	Yes	☐	No	☐
Medicare:	Yes	☐	No	☐

If your answer is <u>No for all of the above</u>, please return this form via fax, mail or email to: (716) 541-6672 or mail to:

Meritain Health
Eligibility Department
P.O. Box 27337
Lansing, MI 48909

Fax number (716) 541-6672

Email: Forms.Direct@meritain.com

If you answered <u>Yes</u> to any of the above, please provide the information below and return as directed above.

MEDICAL

Name of insurance company: Name of: _____

policyholder: Effective date of coverage: _____

Please list **<u>all</u>** family members covered by this plan: _____

_____

MEDICARE

Name of policyholder: _____

Effective date of coverage: _____

Please list **<u>all</u>** family members covered by this plan: _____

_____

Dependent Verification for Health Coverage

Documentation must be provided if you wish to add a dependent (spouse, child, partner or partner's child) to your health coverage. Health coverage affected includes medical, dental, dependent life and family accidental death and personal loss insurance. **All supporting documentation (as described below) must be received prior to your coverage begin date.**

❒ This certifies that all dependents covered under my health insurance are my legal dependents as defined in the MCCCD Benefit Provisions Document. I understand that Insurance fraud is generally defined as the "intentional misrepresentation of material facts and circumstances to an insurance company to obtain payment that would not otherwise be made" and disciplinary action will be taken, up to and including termination, should this occur. In addition, I understand I will be held liable for any claims or fees incurred for the individual that is not a dependent.

Print Employee Name _____ Employee ID _____

Signature of Employee _____ Date _____

❒ This certifies that proper documentation was received to verify that all dependents covered on MCCCD's health insurance are legal dependents as defined in the MCCCD Benefit Provisions Document.

Documentation Provided Includes:

Proof for Dependent Child

- ☐ Birth Certificate
- ☐ Document from Hospital with Name and Birth Date
- ☐ Adoption papers
- ☐ Legal Guardianship substantiated by a Court Order
- ☐ Medical Support Court Order
- ☐ Other _____

Proof for Dependent Spouse or a Domestic Partner

- ☐ Marriage License
- ☐ MCCCD Affidavit of Domestic Partnership with supporting information
- ☐ Other _____

Signature of Benefit Analyst _____ Date _____

List of Acceptable Documents

Documentation must be provided if you wish to add a dependent (spouse, child, partner or partner's child) to your health coverage. Health coverage affected includes medical, dental, dependent life and family accidental death and personal loss insurance. **Social Security #'s or qualified alternate ID #'s are required for all dependents.** Photocopies of document are accepted.

Required Attachments to Enroll a Dependent in Coverage:

Proof for Dependent Child

- Birth Certificate
- Document from Hospital with Name and Birth Date
- Adoption papers
- Legal Guardianship substantiated by a Court Order
- Medical Support Court Order

Proof for Dependent Spouse or a Domestic Partner

- Marriage License
- MCCCD Affidavit of Domestic Partnership with supporting information

Dependent Definitions

A dependent child consists of: the employee's children or the children of the employee's spouse. This includes natural children, legally- adopted children, step children, children placed for adoption, children under legal guardianship substantiated by a court order and living with the employee and children who are entitled to coverage under a medical support order. Dependent children's spouses and/or children are not eligible dependents of the employee.

Children of a Domestic Partner consist of: The children of the domestic partner, including natural children, legally adopted children and children under legal guardianship substantiated by a court order. These children are eligible for dependent coverage if they are primarily dependent on the domestic partnership for support, reside with the domestic partners in a regular parent child relationship, meet the age/school requirements of the benefit plan and meet the definition of an eligible child under the Internal Revenue Service Code § 152.

Required Attachments to the Flex Benefit Change Request

Only one form of verification is needed in each qualifying category. Dependent Verification and Beneficiary listings should also be updated as needed. Photocopies accepted.
Note: For those situations not listed, contact your benefit analyst.

Birth

- Birth Certificate
- Document from Hospital with Name and Birth Date

Adoption

- Adoption papers
- Legal Guardianship with Intention to Adopt
- Certificate of Credible Coverage (Proof of prior coverage)

Marriage/Domestic Partnership

- Marriage Certificate
  - Marriage License can be used until Marriage Certificate comes in
- MCCCD Affidavit of Domestic Partnership
  - Must provide required documentation
- Certificate of Credible Coverage (Proof of prior coverage)

Divorce/Annulment/Separation

- Final Divorce Decree
- Legal Separation Document
- Annulment Document
- MCCCD Termination of Domestic Partnership

Dependent Child(ren) becomes eligible

- Legal Custody (Court Order)
- Medical Support Court Order
- Proof of Loss of Insurance
- Birth Certificate (relocation)
- Certificate of Credible Coverage (Proof of prior coverage)

Death

- Death Certificate (Original for life insurance claims)
- Newspaper clipping or announcement

Dependent (Spouse, Child, Partner) Employment

- Verification of insurance from dependent's employer
- MCCCD Employee Health Insurance Waiver Request

Dependent (Spouse, Child, Partner) Employment Termination

- COBRA notice
- Company letter stating loss of insurance
- Certificate of Credible Coverage (Proof of prior coverage)