Flexplan Service Form

Benefit Election Changes

HSHS Colleague Service Center
Benefit Questions? 1-855-FYI-HSHS
You care for our patients. We care for you.

Name: **Employee ID#:**

Following a qualifying life event, you have 30 days from the date of the event to submit changes to your benefit elections and provide the required supporting documentation. If more than 30 days have elapsed since the date of the qualifying life event, you will not be permitted to make benefit election changes until annual enrollment or you experience another qualifying life event. Benefit changes must be consistent with the life event.

Qualifying Life Event

☐ Birth / Adoption ☐ Change in Marital Status ☐ Gain / Loss of Other Coverage
☐ Death of Dependent ☐ Other *(please specify)*: _____

Date of Qualifying Life Event _____/_____/_____

Medical Insurance

☐ No Change
☐ Cancel Coverage
☐ Elect or Change Coverage ☐ Basic ☐ High
☐ Colleague ☐ Colleague + Spouse ☐ Colleague + Child(ren) ☐ Family

Dental Insurance

☐ No Change
☐ Cancel Coverage
☐ Elect or Change Coverage ☐ Basic ☐ High
☐ Colleague ☐ Colleague + Spouse ☐ Colleague + Child(ren) ☐ Family

Vision Insurance

☐ No Change
☐ Cancel Coverage
☐ Elect or Change Coverage ☐ VSP WellVision
☐ Colleague ☐ Colleague + Spouse ☐ Colleague + Child(ren) ☐ Family

Flexible Spending Accounts

☐ No Change
☐ Cancel Coverage
☐ Elect or Change Coverage
☐ Health Care Reimbursement Account Amount Per Pay $_____ ***OR*** Annual Amount $_____
☐ Dependent Care Reimbursement Account Amount Per Pay $_____ ***OR*** Annual Amount $_____

Identity Theft Protection

☐ No Change
☐ Cancel Coverage
☐ Elect or Change Coverage ☐ Identity Theft Protection
☐ Colleague ☐ Colleague + Family

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Your current elections for Supplemental Life and Voluntary AD&D insurances (if applicable) will remain in effect unless you make a change below. Please note that changes may not be permitted for certain life events.

Supplemental Life Insurance ***An increase in supplemental life insurance coverage may require evidence of insurability***

Colleague*	☐ Tobacco User	☐ Non-Tobacco User			
	☐ 1x salary	☐ 2x salary	☐ 3x salary	☐ 4x salary	☐ 5x salary
	☐ 6x salary	☐ 7x salary	☐ 8x salary		
Spouse*	☐ $5,000	☐ $10,000	☐ $15,000	☐ $20,000	☐ $25,000
	☐ $30,000	☐ $35,000	☐ $40,000	☐ $45,000	☐ $50,000
Child(ren)	☐ $2,500	☐ $5,000	☐ $7,500	☐ $10,000	

Voluntary Accidental Death & Dismemberment Insurance

☐ Colleague Only ☐ Family	☐ $50,000	☐ $100,000	☐ $150,000	☐ $200,000	☐ $250,000

List dependents to be added or deleted *(if more space is needed, attach another page)*

Add or Delete	SSN#	Name	Gender	Relationship	Date of Birth
Delete			Female		
Delete			Female		
Delete			Female		
Delete			Female		

I authorize the premiums for the elected coverage to be deducted from my paycheck and understand that premiums for the elected coverage will be assessed beginning with the date of the qualified life event. By my signature below, I attest that all information submitted on this form and contained in the supporting documentation provided is true and accurate and I affirm my understanding of the statements herein.

Signature: **Date:**

Examples of Supporting Documentation

- Birth – Birth Certificate
- Adoption – Court-Issued Adoption Decree/Certificate
- Marriage – Official Marriage License/Certificate
- Divorce – Court-Issued Dissolution of Marriage
- Gain/Loss of Other Coverage - Proof of loss or gain of other coverage that includes effective date
- Death of Dependent – Official Death Certificate

IMPORTANT: Wisconsin Vital Records may not be transmitted electronically. Original, official birth certificates, death certificates and/or marriage licenses issued in the State of Wisconsin must be presented to your Human Resources Department for annotation/verification. You will be provided the verification/annotation to submit with this form.

Please submit this form and all supporting documentation to the HSHS Colleague Service Center Email: FYI@HSHS.org Fax: 217-492-5896

Have questions? Contact the HSHS Colleague Service Center at 855-394-4747.