

# Benefit Plan Administrators – 2022 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 \_\_\_\_\_

Dependent(s):  Add  Delete  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

<b>Current:</b>	<b>Change To:</b>	<b>Cancel:</b>	<b>Deductible Change*</b>
<input type="checkbox"/> Employee Medical	<input type="checkbox"/> Employee Medical	<input type="checkbox"/> Employee Medical	<input type="checkbox"/> to Traditional Plan
<input type="checkbox"/> Family Medical	<input type="checkbox"/> Family Medical	<input type="checkbox"/> Family Medical	<input type="checkbox"/> to HDHP / HSA Plan
<input type="checkbox"/> Employee Vision	<input type="checkbox"/> Employee Vision	<input type="checkbox"/> Employee Vision	
<input type="checkbox"/> Family Vision	<input type="checkbox"/> Family Vision	<input type="checkbox"/> Family Vision	
<input type="checkbox"/> Employee Dental	<input type="checkbox"/> Employee Dental	<input type="checkbox"/> Employee Dental	
<input type="checkbox"/> Employee + 1 Dental	<input type="checkbox"/> Employee + 1 Dental	<input type="checkbox"/> Employee + 1 Dental	
<input type="checkbox"/> Family Dental	<input type="checkbox"/> Family Dental	<input type="checkbox"/> Family Dental	
<input type="checkbox"/> Life Insurance	<input type="checkbox"/> Life Insurance	<input type="checkbox"/> 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.

## **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 Benefit Plan Administrators of Eau Claire Inc. or your employer 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 BPA or your employer 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.