

2020 Change of Status Benefit Enrollment Form



A request to change, cancel, or add coverage, as well as submission of all necessary supporting documentation, **MUST** be made/submitted **no later than 31 days from the date of the qualifying event** (60 days for Medicare and Medicaid). Please note that the day of the qualifying event counts as day 1. Please refer to the Qualifying Life Event chart on Missionandme.com for details on what changes are allowed, the supporting documentation required and the deadline for submission.

Personal Information

Employee Name:		Employee Number:	Today's Date:																																																																																					
Date of Qualifying Life Event (QLE):		Home Phone:	Work Phone:																																																																																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">Check Box that Applies</th> <th rowspan="2">Name</th> <th rowspan="2">Relationship</th> <th rowspan="2">Birthdate</th> <th rowspan="2">REQUIRED - not required for the addition of a newborn. Social Security #</th> <th rowspan="2">Sex M/F</th> <th rowspan="2">Handicapp Y/N</th> </tr> <tr> <th>ADD</th> <th>DROP</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>		Check Box that Applies		Name	Relationship	Birthdate	REQUIRED - not required for the addition of a newborn. Social Security #	Sex M/F	Handicapp Y/N	ADD	DROP	<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>											
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- Health
- Accident
- Critical Illness
- Hospital Indemnity
- Dental
- Vision
- Dependent Life
- Identity Theft

If you are adding or dropping dependents and have a Flexible Spending Account, you may be able to increase or decrease your contribution. Please see the Flexible Spending Account Enrollment/Change Form on www.missionandme.com

	Change From	Change To
HEALTH <input type="checkbox"/> MCP Plan <input type="checkbox"/> HSP Plan	<input type="checkbox"/> No Coverage <input type="checkbox"/> Employee (EE) <input type="checkbox"/> EE + Spouse * <input type="checkbox"/> EE + Child	<input type="checkbox"/> Employee (EE) Only <input type="checkbox"/> EE + Children <input type="checkbox"/> EE + Spouse * <input type="checkbox"/> Family <input type="checkbox"/> EE + Child <input type="checkbox"/> Terminate Coverage (Proof of Coverage Required)
DENTAL <input type="checkbox"/>	<input type="checkbox"/> No Coverage <input type="checkbox"/> Employee (EE) <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child	<input type="checkbox"/> Employee (EE) Only <input type="checkbox"/> EE + Children <input type="checkbox"/> EE + Spouse <input type="checkbox"/> Family <input type="checkbox"/> EE + Child <input type="checkbox"/> Terminate Coverage (Proof of Coverage Required)
VISION <input type="checkbox"/>	<input type="checkbox"/> No Coverage <input type="checkbox"/> Employee (EE) only <input type="checkbox"/> Employee (EE) + two or more	<input type="checkbox"/> Employee (EE) Only <input type="checkbox"/> EE + Children <input type="checkbox"/> Employee (EE) + one <input type="checkbox"/> Employee (EE) + two or more <input type="checkbox"/> Terminate Coverage
DEP LIFE <input type="checkbox"/>	<input type="checkbox"/> No Coverage <input type="checkbox"/> Spouse \$30,000 <input type="checkbox"/> Spouse \$40,000 <input type="checkbox"/> Spouse \$50,000	<input type="checkbox"/> Employee (EE) + one <input type="checkbox"/> Employee (EE) + one <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Spouse \$30,000 <input type="checkbox"/> Spouse \$40,000 (EOI Required) <input type="checkbox"/> Spouse \$50,000 (EOI Required) <input type="checkbox"/> Terminate Coverage
Other Cov. Write in Plan Type		

*If you are covering your spouse on your Health Plan, you MUST complete the "Spouse Coverage Questionnaire" on the back of this form.

CHANGE REASON	<input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Death* <input type="checkbox"/> Divorce* * will receive COBRA notification through employer	<input type="checkbox"/> Spouse/child lost or gained cover through Mission Employee ID # _____ <input type="checkbox"/> Spouse/child gained/lost coverage through employer <input type="checkbox"/> Ineligible Dependent* <input type="checkbox"/> Called for Active Duty <input type="checkbox"/> Other _____
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Please provide current address for any terminating dependent if different from employee's.

Name: _____	Name: _____	Name: _____
_____	_____	_____
_____	_____	_____

I Hereby Agree My Benefits Will Be Changed As Shown Above.
 I understand that if I drop coverage for myself or any dependents that I am only allowed to request coverage again during an annual enrollment period or if I experience a Qualifying Life Event (QLE) that would make me eligible to enroll and that submission of enrollment form and all required supporting documentation would have to be submitted by the deadline associated with the QLE.

X

Employee Signature (Required in Ink)	Date:
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Please fax, mail or drop completed form with supporting documentation to:

Human Resources 1 Hospital Drive, Suite 6300 Asheville, NC 28801	Fax: (828)213-4223; Email: NCDV.HRDirectConnect@HCAHealthcare.com Contact HR Direct Connect (828) 213-5600
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Spouse Coverage Questionnaire

Employee Name: _____ Employee Number: _____

Complete this questionnaire if you are covering a spouse on your HEALTH plan

1. Is your spouse employed? YES NO
2. Is your spouse employed by Mission Hospital, Mission Medical Associates (MMA), Blue Ridge Regional, Angel Medical Center, Transylvania Regional Hospital, McDowell, CarePartners or Highlands-Cashiers Hospital? YES NO
3. Is your spouse eligible for health insurance coverage available through his/her employer? YES NO