2021 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.

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

Personal Information

Employee Name:	Employee Number:	Today's Date:
Date of Qualifying Life Event (QLE):	Home Phone:	Work Phone:

Health	Accident	Critical Illness	Hospital Indemnity	Dental	Vision	Dependent Life	Identity Theft	Check Box that Applies: ADD	DROP	Name	Relationship	Birthdate	REQUIRED - not required for the addition of a newborn. Social Security #	Sex M/F	Handicap Y/N
❑	❑	❑	❑	❑	❑	❑	❑								
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❑	❑	❑	❑	❑	❑	❑	❑								

	Change From	Change To
HEALTH ❑ MCP Plan ❑ HSP Plan	[ ] No Coverage [ ] Employee (EE) [ ] EE + Children [ ] EE + Spouse * [ ] Family [ ] EE + Child	[ ] Employee (EE) Only [ ] EE + Children [ ] EE + Spouse * [ ] family * [ ] EE + Child [ ] Terminate Coverage (Proof of Coverage Required)
DENTAL ❑	[ ] No Coverage [ ] Employee (EE) [ ] EE + Children [ ] EE + Spouse [ ] Family [ ] EE + Child	[ ] Employee (EE) Only [ ] EE + Children [ ] EE + Spouse [ ] Family [ ] EE + Child [ ] Terminate Coverage (Proof of Coverage Required)
VISION ❑	[ ] No Coverage [ ] Employee (EE) only [ ] Employee (EE) + one [ ] Employee (EE) + two or more	[ ] Employee (EE) Only [ ] Employee (EE) + two or more [ ] Employee (EE) + one [ ] Terminate Coverage
DEP LIFE ❑	[ ] No Coverage [ ] Spouse $30,000 [ ] Child(ren) $5,000 [ ] Spouse $40,000 [ ] Child(ren) $10,000 [ ] Spouse $50,000	[ ] Spouse $30,000 [ ] Spouse $40,000 (EOI Required) [ ] Child(ren) $5,000 [ ] Spouse $50,000 (EOI Required) [ ] Child(ren) $10,000 [ ] 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

[ ] Birth
[ ] Marriage
[ ] Death*
[ ] Divorce*
* will receive COBRA notification

[ ] Spouse/child lost or gained cover through Mission Employee ID #________________
[ ] Spouse/child gained/lost coverag through employer

[ ] Ineligible Dependent*
[ ] Called for Active Duty
[ ] Other__________________

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:

Please email completed form with supporting documentation to:

Email: MissionBenefits@sba-inc.com
Contact HR Direct Connect (828) 213-5600

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 an HCA affiliate, Mission Hospital or a participating employer including Angel Medical Center, Asheville Specialty Hospital, Blue Ridge Regional Hospital, CarePartners, Highlands-Cashiers Hospital, Mission Children's Hospital, , Mission Health Community Multispecialty Providers LLC, Healthy State, Mission Employer Solutions, Mission Health Partners, Mission Hospital McDowell, or Transylvania Regional Hospital? ☐ YES ☐ NO

3. Is your spouse eligible for health insurance coverage available through his/her employer? ☐ YES ☐ NO