Gustavus Adolphus College Status Change Form

EMPLOYER SECTION: To be completed by employer.

Employee Name (please print)	ID #

The employee may change salary reduction and allocation of benefits during the plan year only if they experience a Qualifying Life Event. Check Change in Status reason:

Date of Change_____

- ☐ Married
- ☐ Divorced
- ☐ Spouse commenced or terminated employment
- ☐ Death of a dependent
- ☐ Unpaid leave of absence by employee
- ☐ Unpaid leave of absence by spouse
- ☐ Return to full-time student
- ☐ Other_____

Contributions change on payroll date_____

- ☐ A child is born or adopted
- ☐ A dependent child reaches the coverage limit of the plan
- ☐ Change in full-time or part-time employment for employee
- ☐ Change in full-time or part-time employment for spouse
- ☐ Return to work following leave of absence for employee
- ☐ Return to work following leave of absence for spouse
- ☐ No longer a full-time student

NOTE: For protection, written proof of the change in status should be required of the employee. Notify payroll of new salary reduction amount.

EMPLOYEE SECTION: To be completed by employee.

↓INDICATE CHANGES ONLY↓

Life Plan	■	Basic Life Amount - 1½ x annual pay ($550,000 maximum)		
	Age____ ☐	Voluntary Employee Life Amount	$_____	$_____
	Age____ ☐	Voluntary Spouse Life Amount	$_____	$_____
			(subject to underwriting)*	
	☐	Voluntary Child Life Amount $_____		$_____
	☐	I waive Voluntary Employee Life coverage		
	☐	I waive Voluntary Spouse Life coverage		
	☐	I waive Voluntary Child Life coverage	**A completed Evidence of Insurability form is required. Please request from HR.*	
Accidental Death and Dismemberment	☐	Voluntary Employee AD&D Amount $_____		$_____
	☐	Voluntary Family AD&D Amount $_____		$_____
	☐	I waive Voluntary AD&D coverage		

Medical Plan

$2,500-$40 Copay Plan

- ☐ Employee ($218.95)
- ☐ Employee + Spouse ($618.95)
- ☐ Employee + Child(ren) ($557.95)
- ☐ Family ($897.95)
- ☐ I waive **ALL** medical plan coverage

Medical Plan

$4,000-100% HSA Plan

- ☐ Employee ($75.95)
- ☐ Employee + Spouse/Partner ($257.95)
- ☐ Employee + Child(ren) ($268.95)
- ☐ Family ($493.95)

$6,000-100% HSA Plan

- ☐ Employee ($44.95)
- ☐ Employee + Spouse/Partner ($171.95)
- ☐ Employee + Child(ren) ($178.95)
- ☐ Family ($338.95)

Health Savings Account *

- ☐ Monthly Total $_____
- ☐ I choose not to participate

Gustavus contributes to your HSA in the annual amount of $250 single & $500/all others. This contribution counts toward your annual maximum contribution which is **$3,550 for a single, $7,100 for family. If you are age 55+ you can contribute an additional $1,000. See benefit guide for more details.*

Dental Plan

- ☐ Employee ($15.95)
- ☐ Employee + One ($51.95)
- ☐ Family ($80.95)
- ☐ I waive Dental coverage

Vision Plan

- ☐ Employee ($4.32)
- ☐ Employee + Spouse ($8.20)
- ☐ Employee + Children ($8.63)
- ☐ Family ($12.69)
- ☐ I waive Vision coverage

Disability Plan

- ■ Short Term Salary Continuation (Salaried Employees Only)
- ■ Short Term Disability (Hourly Employees Only)
- ■ Long Term Disability

Medical Flexible Spending Account

- ☐ Plan Year Total Expense $_____ (Minimum $200/Maximum $2,700 per year)
- ☐ I choose not to participate

Dependent Care Account

- ☐ Plan Year Total Expense $_____ (Maximum $5,000 per year)
- ☐ I choose not to participate

Legal Plan

- ☐ Family ($18.95)
- ☐ I choose not to participate

ID Shield

- ☐ Individual ($8.95)
- ☐ Family ($18.95)
- ☐ I choose not to participate

Legal & ID Shield

- ☐ Individual ($27.90)
- ☐ Family ($33.90)
- ☐ I choose not to participate

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DEPENDENT INFORMATION (Complete the following information for each dependent (including spouse) to be covered.)

Name: Last, First, MI	Date of Birth MM	DD	YYYY	Relationship	Gender (M / F)	Social Security Number ***(Required)***	Check For Each Dependent
							☐ Medical ☐ Vol. Life ☐ Dental ☐ Legal ☐ Vision ☐ ID Theft
							☐ Medical ☐ Vol. Life ☐ Dental ☐ Legal ☐ Vision ☐ ID Theft
							☐ Medical ☐ Vol. Life ☐ Dental ☐ Legal ☐ Vision ☐ ID Theft
							☐ Medical ☐ Vol. Life ☐ Dental ☐ Legal ☐ Vision ☐ ID Theft
							☐ Medical ☐ Vol. Life ☐ Dental ☐ Legal ☐ Vision ☐ ID Theft

(List additional children on a separate sheet of paper. Also provide address for children if different from employee's mailing address.)

OTHER INSURANCE INFORMATION: Please complete if electing medical or dental on yourself and/or dependents at this time.
Other insurance information is necessary in order to coordinate benefit payments with other insurance companies. Other insurance may include, but is not limited to: coverage through a spouse's plan, court ordered insurance coverage by a former spouse, coverage required in a divorce decree or paternity suit, or Medicare. If you provide incorrect or inadequate information, claims may be delayed or denied.

Are you or any of your family members covered under any other group medical or dental plan? ☐ Yes ☐ No
If you checked yes, you must provide the following information. If you have more than one policy in force, please attach a separate sheet to this form which lists the following information for each policy.

Policyholder's Name	Policyholder's Birthdate	
Policyholder's Employer Name	Address	Phone Number
Insurance Company Name and Phone Number	Policy Number	Family Members Covered

Is coverage for any of the above listed individuals required due to a court order, divorce decree or paternity suit? ☐ Yes ☐ No
If yes, please attach a copy of the section of the court order or divorce decree pertaining to health coverage.

SIGNATURE (required)

I hereby certify that the information I have provided is true and correct, and I authorize any insurance company, plan administrator, or educational institution to release any information regarding other insurance coverage or student status regarding me or my covered dependents for the purpose of benefit coordination.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION ON THIS FORM MAY RESULT IN THE DENIAL OF CLAIM(S) AND/OR TERMINATION OF COVERAGE.

Employee Name (print)_____ID # _____

Employee Signature_____Date_____

Submit Form