

Medical/Dental Coverage CHANGE Form

Ancira Employee Benefits
2009-10 Change Form
76-410069

- QUALIFIED Change IN COVERAGE and/or DEPENDENTS
- ATTACH SECTION 125 FORM if changing Medical or Dental (www.ancira.org > Forms)
- Change of Address or Phone ONLY (You must also inform payroll department @ 231-4417)

SECTION 1: What is your CURRENT COVERAGE with Ancira?

(view your most recent pay voucher detail)

CURRENT MEDICAL with Ancira:

- HCA Entry Plan None
- Self Self + Spouse Self + Child Family

CURRENT DENTAL with Ancira: Self Self + 1 Family None

CURRENT LIFE election with Ancira: Self Self & Spouse Self, Spouse and Child/ren None

This form is to Add or Change
Medical, Dental, and/or Terminate
Individual Group Life Benefits.

SECTION 2: PERSONAL INFO

NAME:	LAST,	FIRST	M.I.	Store	Dept	Employee ID#
ADDRESS	CITY	STATE	ZIP	HIRE DATE:		
Social Security#:			Home Email Address: (optional)			
DATE OF BIRTH	GENDER	MARITAL STATUS		HOME TELEPHONE NUMBER ()		

SECTION 3: COVERAGE CHANGE INFORMATION

COMPLETE THIS SECTION ONLY IF MAKING CHANGES TO MEDICAL OR DENTAL: **WHAT COVERAGE DO YOU WANT?**

<p>Health Coverage:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Medical HCA Bucket Plan \$120/\$345/\$595 <input type="checkbox"/> Entry Plan* (OFF Ancira insurance since 6/1/08 or HIRED 2/1/08 OR LATER, this is your only option) \$75/\$205/\$300 <input type="checkbox"/> Waive - attach proof of other coverage and sign waiver on back of this page <p>Check only one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee plus child <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Family <p style="font-size: small;">} Note: plus child or spouse are the middle-tier rate</p> <p>Note: Texas True Choice is your <u>medical</u> network If adding yourself and/or spouse to the HCA PLAN, Lab and Health Risk Assessment are required. Call 558-5005 for info.</p>	<p>Dental Coverage:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dental Plan: Guardian Preferred Select \$20/\$35/\$50 <input type="checkbox"/> Waive <p>Check only one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee plus child <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Family <p style="font-size: small;">} Note: plus child or spouse are the middle-tier rate</p> <p>Note: Guardian Preferred Select is your <u>dental</u> network</p>
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SECTION 4: HIPAA - ALTERNATE COVERAGE RECORD

COMPLETE THIS SECTION ONLY IF YOU'RE ADDING COVERAGE OR DEPENDENTS UNDER MEDICAL OR DENTAL

Adding MEDICAL coverage? No Yes

Adding DENTAL coverage? No Yes

Will this person have ANY OTHER medical/dental coverage? No Yes, single Yes, family

If yes to the above question, complete the following: Coverage WILL BE DUPLICATED for MEDICAL DENTAL

NAME/S OF ALL PERSONS COVERED THROUGH THIS OTHER PLAN:

Employer Name _____ Carrier Name _____ Plan Number _____

SECTION 5: GROUP LIFE COVERAGE Change

Terminate Life Insurance Coverage for

- Dependents Only: (names) _____
- Self (terminating Self auto-terminates any dependents you have covered under your policy)

Note: If you have the Ancira medical insurance Standard PPO or HCA, you retain \$10,000 in Life/AD&D

**IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES,
PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.**

*See the Applicable Reader-Friendly Benefits Books posted at www.ancira.org > My Benefits

**Proof of Creditable Coverage is a standard form that insurance carriers use to communicate your prior insurance benefits to a new carrier. It's available by contacting the prior carrier to fax or mail it to you.

SECTION 6: PERSONAL & DEPENDENT DATA

If we have questions, what's the best number to reach you? _____

- Dependents must meet IRS and policy definitions of "dependent"
- Certificate of Common Law issued by your county of residence is required for Common Law dependents; otherwise your request will be denied.
- Coverage cannot be canceled if an active child support order is on file with your employer. If your change is a result of you being RELEASED from a court-ordered dependent medical support, ATTACH A COPY OF THE STATE RELEASE TO YOUR CHANGE FORM.

This one form is intended to communicate a variety of EMPLOYEE OPTIONS.
 You must WRITE THE FOLLOWING: A for ADD; C for CHANGE; D for DECLINE or E for END EXISTING coverage

A, C, D or E	First, Middle Initial, and Last Name PRINT	Social Security #	Birthdate mm-dd-yy	Does this child live with you?	Is this child a legal TAX Dependent?	Do you provide more than 50% support?	Notes or Special Instructions
	Employee						
	Spouse						
	[]son []daughter						
	[]son []daughter						
	[]son []daughter						
	[]son []daughter						

COPY THIS PAGE if you have more DEPENDENTS than this page allows.
 STAPLE YOUR PAGES TOGETHER FIRMLY.

Medical or Dental **changes** require Section 125 form (see www.ancira.org).

If you are requesting MEDICAL INSURANCE for a dependent CHILD:

- Is your child 19 years old or more? Yes No Over 23? Yes No
- If YES: Is THIS DEPENDENT a FULL TIME STUDENT (12+ hrs.)? Yes No
- If you answered YES, SAVE TIME by going online to www.ancira.org > My Benefits

Print the required Student Dependent Certification and staple it to this form. You must complete a student certificate annually or coverage may be retroactively terminated. You will forfeit premiums collected prior to 60-day mark. If a child doesn't share your last name, complete the DEPENDENT CERTIFICATION and staple it to this form.

By signing, I ACKNOWLEDGE receiving notice of HIPAA PRIVACY policy and Benefits information and authorize the foregoing changes to coverage and related payroll deductions for premiums which will be reflected in the specific insurance deduction section of my pay voucher detail. If adding Self and/or Spouse to HCA, I accept responsibility for complying with the HRA/Lab requirements and submitting the required information to UMR Wellness*. If terminating coverage, I understand that without a qualified event, I will be required to wait until my employer's open enrollment to change this decision and will be subject to underwriting and waiting periods the policy may require. This form shall supersede all former elections and beneficiary designations, as applicable. I understand premiums are collected a month in advance of coverage/policy effective dates to ensure timely payment to carriers and unless otherwise allowed by Section 125 regulations, my change will not be effective until the following 1st of the month in which this form is finalized by the Team Services - Benefits office. My failure or delays to provide requested supporting documents may compromise my request for a change and/or prevent a change from being allowed. [*If you do not know what this means, call 210-558-5005 or email teamservices@ancira.com]

I hereby certify that all of the information provided by me is true, complete and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet, Summary Plan Description, or Plan Document for full details of your benefit plan.
 ALL FORMS MUST BE RECEIVED THROUGH THE ANCIRA TEAM SERVICES - BENEFITS OFFICE FOR PROCESSING.

 EMPLOYEE SIGNATURE

 DATE

NOTE: DISABILITY (Income Insurance) COVERAGE is not managed using this form. Direct any questions to 800-207-3172.

DO NOT WRITE IN THIS BOX - TEAM SERVICES OFFICE USE ONLY

____ TS Trak ____ UMR ____ HRA>EE/Sp ____ COB ____ PR ____ ING Enr ____ ING eoi