Locke Lord LLP

HUMAN RESOURCES

Change of Status Form Flex Benefit Plans

IMPORTANT: CHANGES MUST BE MADE WITHIN 30-DAYS OF THE QUALIFYING LIFE EVENT

Name of Participant: _____

Date of Status Change: _____

I, the above-named Participant, experienced the following status change (check one):

- ☐ 1. Marriage/Civil Union
- ☐ 2. Divorce or Legal Separation
- ☐ 3. Birth or Adoption of a Child
- ☐ 4. Death of Spouse/Domestic Partner or Dependent
- ☐ 5. Commencement of Spouse/Domestic Partner's Employment
- ☐ 6. Termination of Spouse/Domestic Partner's Employment
- ☐ 7. Spouse/Domestic Partner's Change from Part-Time to Full-Time Employment
- ☐ 8. Spouse/Domestic Partner's Change from Full-Time to Part-Time Employment
- ☐ 9. Overage Dependent Child (turned age 26)
- ☐ 10. Spouse/Domestic Partner's Open Enrollment
- ☐ 11. Change in Dependent Status of Child (returned to school/job change/loss)
- ☐ 12. Enrollment in Medicare
- ☐ 13. Other _____

I wish to make the following benefit election changes:

☐ **Add Medical** coverage for:

Plan requested:
- ❑ BCBSIL Base Plan
- ❑ BCBSIL HDHP w/HSA Plan

- ☐ Self
- ☐ Spouse
- ☐ Domestic Partner/Civil Union
- ☐ Child(ren)

Please include Name, DOB & SSN for each dependent to be covered.

_____

_____

_____

☐ **Drop Medical** coverage for:

☐ Self ☐ Spouse ☐ Domestic Partner/Civil Union ☐ Child(ren)

Name(s): _____

☐ **Add Dental** coverage for:

Plan Requested:
❑ Delta Dental of Texas

☐ Self
☐ Spouse
☐ Domestic Partner/Civil Union
☐ Child(ren)

Please include Name, DOB & SSN for each dependent to be covered.

_____
_____
_____

☐ **Drop Dental** coverage for:

☐ Self ☐ Spouse ☐ Domestic Partner/Civil Union ☐ Child(ren)

Name(s): _____

☐ **Add Vision** coverage for:

Plan Requested:
❑ VSP

☐ Self
☐ Spouse
☐ Domestic Partner/Civil Union
☐ Child(ren)

Please include Name, DOB & SS# for each dependent to be covered.

_____
_____
_____

☐ **Drop Vision** coverage for:

☐ Self ☐ Spouse ☐ Domestic Partner/Civil Union ☐ Child(ren)

Name(s): _____

☐ **FSA/DSA/HSA** changes: _____

_____

_____

☐ Other requests and/or comments: _____

_____

_____

I hereby revoke my current election and make the indicated *new* election under the Flex Benefit Plan for the remainder of the current plan year. I understand and certify that my revocation and new election is consistent with my life status change.

Participant Signature:_____ Date:_____

Administrator Signature:_____ Date:_____

PDF your completed Life Status Change form along with your proof of coverage/cancellation or other required documentation **WITHIN 30-DAYS** of the qualifying event to: HRHotline@lockelord.com

Questions? Contact the HR Hotline at 401.455.7670 or HRHotline@lockelord.com.