Cooper University Health Care

Request to Amend Current Benefit Elections – Change in Status Form

A completed Change in Status form must be submitted if you wish to make coverage changes for the current benefit year. If your request is not received in 31 calendar days from the Qualifying Life Event (QLE), no changes can be made until the next Annual Open Enrollment Period. For more information please review the current Benefits Highlights Booklet or contact the HR Benefits department at HRBenefits@cooperhealth.edu

The chart below outlines the list of qualifying life events and the documentation required for each QLE. Requests for change must be consistent with the life event and must be accompanied by the appropriate documentation as noted below. ***Note: when requesting a change to an existing plan, you may request a change in coverage levels, but you may not change plans.***

Event	Definition
Marriage/Domestic Partner/Civil Union	Adding a Spouse or Domestic Partner
Divorce	Legal dissolution of marriage
Birth, Adoption, or Legal Placement	Adding a natural born child, legally adopted child(ren), step-child(ren), or legally placed dependents
Death	Death of employee, spouse, legal dependent
Loss or Gain of Coverage	Letter from current insurer or employer documenting loss or gain of coverage
Dependent	**Acceptable Documentation**
Employee's lawful Spouse	At least one of the following: • Copy of certified marriage license – state/county issued • Copy of most recent Federal tax return listing dependents
Employee's Domestic Partner/Civil Union Partner	• Copy of Domestic Partner or Civil Union Registration – state or county issued
Employee's dependent child or step-child	At least one of the following: • Copy of dependent's birth certificate – state/county/hospital issued ***Footprints, or hospital discharge notes are acceptable for newborns until birth certificate I available and submitted.*** • Copy of most recent Federal tax return listing dependents
Employee's adopted dependent child or foster child	At least one of the following: • Copy of dependent's birth certificate – state/county issued and legal adoption documents from applicable court or government agency • Copy of most recent Federal tax return listing dependents

Child placed with the employee for intent of adoption	• Court order granting the employee custody of the child • Copy of the dependent's birth certificate – state/county issued
An alternate recipient who is covered under qualified medical child support order (QMCSO)	• Copy of the dependent's birth certificate – state/county issued • Copy of the QMCSO that requires the employee to provide coverage
Employee's grandchild in the employee's court-ordered custody	• Copy of the dependent's birth certificate – state/county issued
A child of the employee's domestic partner who: 1. Is a natural or adopted child of the domestic partner 2. Lives with the employee and domestic partner in a parent-child relationship 3. Is dependent on the employee and domestic partner for support, or any child whom the domestic partner has legal guardianship or legal responsibility for, support and maintenance and who live with the employee and domestic partner in a parent-child relationship	• Copy of the dependent's birth certificate – state/county issued • Copy of domestic partner registration or civil union registration
An employee's disabled dependent who is incapable of self-sustaining employment	• Copy of the dependent's birth certificate – state/county issued • Copy of most recent Federal tax return documenting disabled status

This form and required documentation must be submitted to the Benefits Team within ***31 calendar days*** of the qualifying status change event. If all items are not submitted within 31 days, your coverage will remain unchanged for the remainder of the plan year and any additional dependents may not have coverage. Completed forms and documentation can be sent to HRBenefits@Cooperhealth.edu or faxed to 856-968-8519

**Employee supplemental life insurance can be elected in $10,000 increments to a maximum of 5x your annual salary up to $1,000,000. Dependent life insurance can be increments of $5,000. The maximum amount for child(ren) is $10,000, and for a spouse the maximum amount is $25,000. Please refer to Employee Self-Service for supplemental life rates and Benefits Highlights booklet for more information and if an EOI form is required.*

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PERSONAL DATA

Name: _____SS#: _____ EE ID: _____

DOB_____ Address _____FT☐PT☐

Email: _____ Phone: _____

Event Date_____ Event Description_____

***Request for legal name change must be submitted on a Personal Data Form and submitted to HRIS.**

Benefit Elections

Please check the plans and coverage options you would like for the remainder of the plan year

Medical Coverage	Employee Only	Employee + Child	Employee + Children	Employee + Spouse/DP/CU	Employee + Family
Do you used tobacco products?*	Yes ☐	No ☐			
Waive Coverage ☐					
Cooper Basic PPO HDP	☐	☐	☐	☐	☐
Cooper Core PPO	☐	☐	☐	☐	☐
Cooper Standard PPO	☐	☐	☐	☐	☐
Cooper Out of Area PPO**	☐	☐	☐	☐	☐

If no tobacco use attestation noted, you will be defaulted to the "Tobacco user" rate. See the Benefits Highlights Booklet for additional information ** Please verify with the eligibility with the benefits department

Dental Coverage	Employee Only	Employee + Child(ren)	Employee + Spouse/Domestic Partner/Civil Union	Employee + Family
Waive Coverage ☐				
Assurant/Sunlife DMO	☐	☐	☐	☐
Delta Dental Preferred PPO	☐	☐	☐	☐
Delta Dental Buy-up PPO	☐	☐	☐	☐
Vision Coverage	**Employee Only**	**Employee + Child(ren)**	**Employee + Spouse/Domestic Partner/Civil Union**	**Employee + Family**
Waive Coverage ☐				
Eye Med Vision Care	☐	☐	☐	☐

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Supplemental Life Insurance*	No Coverage	Coverage Amount
Employee Supplemental Life Insurance	☐	$
Child Life Insurance	☐	$
Spouse/Domestic/Civil Life Insurance*	☐	$

See page 2 for supplemental life insurance coverage amounts

Flexible Spending Accounts – FSA	No Coverage	Amount
Medical Spending Account – MSA ***minimum $100, maximum of $3,050 for 2023 calendar year***	☐	$
Dependent Care Spending Account – DCSA ***minimum $100, maximum of $5,000 for 2023 calendar year***	☐	$

Voluntary Short Term Disability*	Waive Coverage	30 day elimination	60 day elimination	90 day elimination
	☐	☐	☐	☐

****Please verify your eligibility with the benefits department***

If you are adding or removing a dependent(s) from coverage, please complete the information below:

(A)dd (R)emove	Full Name (Last, First MI)	Social Security #	DOB	Sex (M/F)
	Employee:			
	Spouse/Domestic/Civil:			
	Child:			
	Child:			
	Child:			

I hereby elect the benefit plans selected on this form and agree to the associated deductions from my gross paycheck. I recognize that contributions through payroll deductions are completely voluntary and in compliance with State and Federal law. I understand that I must declare whether I am a tobacco or non-tobacco user and may qualify for a non-tobacco user premium discount. I understand that any dishonest or false representation of my non-tobacco use status will result in termination. Cooper may require me to repay all amounts reduced from my contributions for the period in which I claimed I was eligible for the non-tobacco user discount. I also recognize that I may not make changes to these elections during the calendar year unless I experience another Qualifying Life Event outside of the annual open enrollment period.

Employee Name (printed):_____ Date: _____

Employee Signature: _____ Phone: _____

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Allowed Coverage Changes

Qualifying Life Event	Effective Date	Medical Dental	Supplemental Life	Dependent Life	Flexible Spending
You have a change in your marital status (marriage/divorce)	• First of the following month when adding • End of the month when removing	Enroll yourself, add/drop dependent(s); Decline coverage	Any Change	Any Change	Insurance or Decrease contributions
Change in number of dependents: • Birth of eligible child • Adoption of eligible child	• Adding – Date of event • End of the month when removing	Add or drop dependents	Any Change	Any Change	Insurance or Decrease contributions
Your Dependent either gains or loses coverage due to: • Relocation • Employment Change: Hire/Rehire • Termination • Increase or Decrease in hours (FT to PT or vice versa	• First of the following month when adding • End of the month when removing	Enroll yourself add or drop dependent(s); Decline coverage	Any Change	Any Change	Insurance or Decrease contributions
You or your dependent gains or loses entitlements to COBRA, Medicare or Medicaid	• First of the following month when adding • End of the month when removing	Enroll yourself add or drop dependent(s); Decline coverage	Any Change	Any Change	Insurance or Decrease contributions
Dependent satisfies or ceases to satisfy eligible under plan: • Reaching age limit(26) • Gains coverage with another employer	• First of the following month when adding • End of the month when removing	Add or drop affected dependent	Any Change	Any Change	Insurance or Decrease contributions
Significant increase/decrease in payroll deductions; or loss/gain of coverage due to: • Move from FT benefits eligible status to a PT benefits eligible status or vice versa	• First of the following month when adding • End of the month when removing	For medical and dental, may elect an entirely new plan but may not change current level of coverage	Any Change	Any Change	Insurance or Decrease contributions