Cooper Norcross Health

Request to Amend Current Benefit Elections – Change in Status Form

Please review and select the plans and coverage options you would like to maintain for the remainder of the plan year.

Name:	SSN:	Employee ID:		D.O.B.	☐ Full Time ☐ Part Time
Address:			Email:		Phone:

Do you use tobacco products? *	☐ Yes	☐ No	** If yes or no is not selected to the left, you will be defaulted to the "tobacco user" medical premium rate.*

Medical Coverage	Employee Only	Employee + Child	Employee + Children	Employee + Spouse/DP/Civil	Employee + Family
☐ Waive Coverage					
Cooper Basic HDHP					
Cooper Core PPO					
Cooper Standard PPO					
Cooper Out of Area PPO**					

*** Check with the benefits department to verify your eligibility.*

Dental Coverage	Employee Only	Employee + Child(ren)	Employee + Spouse/DP/Civil	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/DP/Civil	Employee + Family
☐ Waive Coverage				
Eye Med Vision Care				

Supplemental Life Insurance*	Waive Coverage	Coverage Amount
Employee Supplemental Life Insurance	☐	$
Child Life Insurance	☐	$
Spouse/Domestic/Civil Life Insurance*	☐	$

**Refer to the 2027 Benefits Booklet for premiums and coverage amounts.*
**The team member must be insured for employee supplemental life insurance in order to elect spousal coverage*

Flexible Spending Accounts – FSA	Waive Coverage	Election Amount
Medical Spending Account – MSA *minimum $100, maximum of $3,500 for 2027 calendar year*	☐	$
Dependent Care Spending Account – DCSA *minimum $100, maximum of $7,500 for 2027 calendar year*	☐	$

Voluntary Short-Term Disability	☐ Waive Coverage	☐ 30 Day	☐ 60 Day	☐ 90 Day

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

	Child:			
Beneficiary				
(A)dd/(R)emove	**Full Name (Last, First MI) & Home Address**	**Social Security #**	**Primary/Contingent Beneficiary**	**Percentage of Benefit to Receive****

**** If multiple primary or contingent beneficiaries are designated, the total percentage designated for each beneficiary type must equal 100%.**

By signing the below, I acknowledge that I have read and understand this Election Form, as well as the descriptive materials provided by Cooper University Hospital. I understand that I must make contributions for any benefits elected on this form and that all contributions except those for life insurance will be deducted from my pay on a before-tax basis. I also understand that these elections cannot be changed until the next annual enrollment period unless I have a change in family status as defined by law. If I have waived any of the benefit options on this form, I understand that I must comply with the rules that govern late enrollments. I certify that the answers to the questions on this form are complete and accurate. In addition, I understand that I must declare whether I am a tobacco or non-tobacco user and may qualify for a Non-Tobacco Incentive. 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 for which I claimed I was eligible for the non-tobacco user discount. I authorize payment of benefits to network providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by my employer/the insurance company of any health care information (Medical or Dental), including copies of records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits. These authorizations will remain valid during my term of coverage under my group insurance plan. I or my authorized representative may request a copy of this authorization, and a photocopy of this authorization will be considered valid.

Employee Signature: _____ **Date**: _____

The completed and signed Benefit Election Form, along with any required dependent verification documentation, should be submitted to the HR Benefits Department using one of the options below.

We strongly recommend that you contact the HR Benefits Department at 856-342-2403, option 2, to confirm that your documents have been received.

- **Option 1: Mail to the HR Benefits Department:**
  Human Resources
  Attention: HR Benefits Department
  1 Federal St., Suite 200
  Camden, NJ 08103
- **Option 2: Fax to the HR Benefits Department:**
  856-968-8519
- **Option 3: Scan and e-mail to the HR Benefits Department:**
  HRBenefits@cooperhealth.edu