# Enhanced MEC Change Form

## A. Employee Information (*All information is required*)

| | | | |
|---|---|---|---|
| First Name: | MI: | Last Name: | |
| SSN#: | Date of Hire: | | |
| Date of Birth: | Gender: ☐ M or ☐ F | Marital Status: | |
| Address: | City: | State: | Zip: |
| Daytime Phone: ( ) | Home phone: ( ) | Email: | |

## B. Change of Status/Coverage

| | | | |
|---|---|---|---|
| **Date of Qualifying Event:** | | ☐ Add Dependent | ☐ Change Name |
| ☐ Open Enrollment | ☐ Terminate Coverage | ☐ Drop Dependent | ☐ Change Address |
| ☐ New Enrollment | ☐ Medicare | ☐ Birth / Death | ☐ Other |
| ☐ Reduction in Hours | ☐ Other Coverage | ☐ Marriage / Divorce | _____ |

## C. Medical Plan Options (*If electing coverage please make a selection in both 1 & 2*)

| | | | | |
|---|---|---|---|---|
| 1. Plan Election | ☐ Minimum Essential Coverage (MEC) Plan | | ☐ Decline Coverage (please complete section E) | |
| 2. Coverage Election | ☐ Employee only | ☐ Employee + Spouse | ☐ Employee + Children | ☐ Family |

## D. Dependent/Spouse Information (*Must be completed for coverage of dependents*)

| Name (Last, First, MI) | Relationship | Birth date | SSN | M/F | Disabled (Y/N) | Please check below to include on medical plan |
|---|---|---|---|---|---|---|
| | | | | | | ☐ Medical |
| | | | | | | ☐ Medical |
| | | | | | | ☐ Medical |
| | | | | | | ☐ Medical |

## E. Employee Authorization

I understand I have the option to pay the premiums for my employer-sponsored health plan through a before-tax reduction of my salary. I understand that if this amount increases or decreases during the plan year, my salary reduction will be adjusted to reflect that increase or decrease.
I hereby apply for the coverage for which I am now or may be eligible under this group policy. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such coverage. I authorize payment of medical benefits to all providers, where applicable, for those charges covered by my group insurance benefits. I authorize release to or by HealthEZ of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits.

To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I acknowledge that the terms of the Summary Plan Description govern all payments made by the Plans.

_____ _____

Employee Signature Date

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