Liberty Healthcare

Qualifying Events Insurance Form

2025 - 2026 Plan Year

Employee Name:	**Effective Date of Change:**
Employee ID #:	**Social Security #:**
Qualifying Event Reason:	
Office/Facility:	

A Qualifying Event can include but is not limited to loss of other coverage, gaining other coverage, the birth of a child, death of a covered dependent, and marriage. Proof of the qualifying event must be submitted to the Human Resources department along with this form within 30 days of the event date. You can only make changes during the plan year to the coverage/dependents affected by the qualifying event. New coverage elections for the qualifying event will begin on the 1st of the month that the event took place. Coverage cancellations will occur at the end of the month when the event occurs. Insurance premiums for elected coverage plans will be collected or refunded in arrears if necessary.

HEALTH **Please circle Basic, Standard, Premium, or HPN**

Pre-tax deduction: BCBS

Biweekly Cost	Basic	Standard	Premium	HPN
Self Only	$66.51	$108.33	$156.43	$55.38
Self + Spouse*	$262.30	$341.22	$459.03	$218.31
Self + Child(ren)	$171.58	$234.69	$325.83	$143.08
Self + Family*	$355.85	$461.603	$619.81	$296.31

DENTAL

Pre-tax deduction: Delta Dental

Biweekly Cost	Core	Buy Up
Self Only	$13.76	$18.46
Family	$27.64	$40.15

VISION

Pre-tax deduction: Superior Vision

Biweekly Cost	
Self Only	$3.72
Self + One	$7.14
Self + Family	$10.50

I would like to ❍ **Add or** ❍ **Cancel:** ❍ **Health** ❍ **Dental** ❍ **Vision**

For the following: ❍ Self Only ❍ Children ❍ Spouse

Please list the dependents you wish to cover or cancel coverage for:

Spouse: Name: _____ Social Security #: _____-_____-_____ Date of Birth: _____

***SPOUSE HEALTH COVERAGE: If you choose to cover your spouse for health insurance, you must complete and sign the Liberty Spouse Health Coverage Form included with this packet for your spouse to be approved and included for health coverage.**

Child(ren): Child/Eligible Dependent (to age 26)

Name: _____ ❍ Male ❍ Female SS#: _____-____-_____ Date of Birth: _____

Name: _____ ❍ Male ❍ Female SS#: _____-____-_____ Date of Birth: _____

Name: _____ ❍ Male ❍ Female SS#: _____-____-_____ Date of Birth: _____

Name: _____ ❍ Male ❍ Female SS#: _____-____-_____ Date of Birth: _____

Name: _____ ❍ Male ❍ Female SS#: _____-____-_____ Date of Birth: _____

LEGAL NOTICE: By signing this form, I certify that I would like to participate in the plan(s) as indicated. I understand that by signing and submitting this form to elect coverage, I (1.) authorize payroll deductions from my salary, (2.) designate the beneficiary(ies) named on this form to receive any life insurance benefits payable in the event of my death, and (3.) for any pre-tax benefits I selected, I hereby elect to have my compensation reduced each pay period by the amount specified. I also direct my employer to use such amounts, in accordance with the terms of the Flexible Benefits Plan, to pay the premiums for the coverage designated. I further understand that this election is irrevocable during any Plan Year for which it is in effect except in the event of a "change in family status" or "employment status change" as defined by the Plan. If I have a qualifying event, I understand that I may change the above election within 30 days of the qualifying event and make a new one consistent with my qualifying event. I also understand that during the annual enrollment period of each Plan Year, I can elect to make changes to the above deductions. By making this election, I agree to be bound by the terms and conditions of the Plan and acknowledge that the Company may amend or terminate this Plan at any time. I understand that I must consistently work the required number of hours per week to be considered eligible for any healthcare benefits offered and that my benefits may be canceled if I fail to maintain full-time status. I further understand that premium deduction amounts may change and do hereby consent to such changes without the necessity of additional authorization on my part, verbal or written, provided the insurance companies certify in writing that the change in premium uniformly affects all members of the class to which I belong. I further certify that to the best of my knowledge and belief, any information disclosed on this enrollment request is accurate and that my answers to any statements are correct, true, and complete. I understand that I must be actively at work on the effective date, or coverage will be deferred until I return to work.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Updated 3/2023

Signature: _____ **Date** _____

HR USE: ☐ **BN31.2** ☐ **PR39**