diversified
COMMUNICATIONS

Family Status Change & Enrollment Form

Application must be submitted within 30 days of effective date of change

Name: _____ Effective Date of Change: _____

Description of Family Status Change: _____

Instructions: Fill in the blanks with your elected coverage or indicate no changes/decline with a check mark for each benefit option.

Medical Plan Options

Plan Options: HRA Option 1 * HRA Option 2 * PPO Plan
Coverage Level Options: Employee Only * Employee + 1 * Family

I elect the _____ health plan with _____ level of coverage.

No Change: I am not changing Medical coverage. Continue this benefit as originally elected. _____

Decline Medical Coverage: I elect to opt out of medical coverage under the Diversified Communications Group Health Plan. _____
Please see below for important information if you are electing to opt-out of coverage.

Dental Plan

Plan Options: Delta Dental
Coverage Level Options: Employee Only * Employee + 1 * Family

I elect the _____ plan with _____ level of coverage.

No Change: I am not changing Dental coverage. Continue this benefit as originally elected. _____

Decline Dental Coverage: I elect to opt out of dental coverage under the Diversified Communications Group Health Plan. _____
Please see below for important information if you are electing to opt-out of coverage.

Vision Plan

Plan Options: Basic * Enhanced * Easy Options
Coverage Level Options: Employee Only * Employee + 1 * Family

I elect the _____ vision plan with _____ level of coverage.

No Change: I am not changing Vision coverage. Continue this benefit as originally elected. _____

Decline Vision Coverage: I elect to opt out of vision coverage under the Diversified Communications Group Health Plan. _____
Please see below for important information if you are electing to opt-out of coverage.

FSA for Health Care Expenses

FSA Plan Options: Minimum annual election of $50; Maximum annual election of $2,850.

I elect an FSA of $ _____ annually or $_____ per pay period.

No Change: I am not changing FSA elections. Continue this benefit as originally elected. _____

Decline FSA Coverage: I elect to opt out of FSA coverage under the Diversified Communications Group Health Plan. _____
Please see below for important information if you are electing to opt-out of coverage.

Dependent Care Reimbursement Account: Minimum annual election of $50; Maximum annual election of $5,000.

I elect a DCRA of $ _____ annually or $_____ per pay period.

No Change: I am not changing DCRA elections. Continue this benefit as originally elected. _____

Decline DCRA Coverage: I elect to opt out of DCRA coverage under the Diversified Communications Group Health Plan. _____
Please see below for important information if you are electing to opt-out of coverage.

Supplemental Life Insurance

Supplemental Life Plan Options: Elect a coverage volume in $25K increments. Maximum allowable volume is $500K. 1x annual salary is provided to you at no cost by DC. The 1x annual salary volume is added to your elected volume. EOI may be required if your total elected volume is greater than the non-medical maximum.

Employee Supplemental Life Insurance Elected Volume: **$_____**

Spouse Life Insurance Elected Volume: **$_____**

Child Life Insurance (Volume if elected is a flat $10K per child): **$_____**

No Change to Supplemental Life Insurance Elections: _____

Decline Supplemental Life Insurance Coverage: _____

Critical Illness Insurance

Employee – Elect coverage volume in multiples of $10,000 to $30,000: **$**_____

Spouse – Elect coverage volume in multiples of $5,000 to $15,000: **$**_____

Child (up to age 26) **–** Elect coverage volume in multiples of $5,000 to $15,000: **$**_____

No Change to Critical Illness Coverage: _____

Decline Critical Illness Coverage: _____

Accident Insurance

Plan Options: Low Plan * High Plan
Coverage Level Options: Employee Only * Employee + 1 * Family

I elect the _____ Accident plan with _____ level of coverage.

No Change to Accident Insurance Elections: _____

Decline Accident Insurance Coverage: _____

Hospital Indemnity Insurance

Plan Options: Low Plan * High Plan
Coverage Level Options: Employee Only * Employee + 1 * Family

I elect the _____ Hospital Indemnity plan with _____ level of coverage.

No Change to Hospital Indemnity Insurance Coverage: _____

Decline Hospital Indemnity Coverage: _____

Identity Theft Insurance

Plan Options: ID Watchdog
Coverage Level Options: Employee Only * Employee + 1 * Family

I elect the _____ Identity Theft plan with _____ level of coverage.

No Change to Identity Theft Insurance: _____

Decline Identity Theft Insurance Coverage: _____

Dependent Information: Please list all dependents you are enrolling in the Group Health Plan or removing from the Group Health Plan bellow. Social security numbers and dates of birth are required for enrollment.

Dependent Information: Please list all dependents (Name & Social Security Number) you are enrolling or removing in the Group Health Plan.

Dependent's Name	Relationship	Adding or Removing?	Coverage Elected	Other Health Ins.*
1. _____	_____	○ Add ○ Remove	○ Medical ○ Dental ○ Vision	○ Yes ○ No
SS# _____	DOB: _____	Gender Identification: Male Female Non-binary		
2._____	_____	○ Add ○ Remove	○ Medical ○ Dental ○ Vision	○ Yes ○ No
SS# _____	DOB: _____	Gender Identification: Male Female Non-binary		
3._____	_____	○ Add ○ Remove	○ Medical ○ Dental ○ Vision	○ Yes ○ No
SS# _____	DOB: _____	Gender Identification: Male / Female / Non-binary		
4._____	_____	○ Add ○ Remove	○ Medical ○ Dental ○ Vision	○ Yes ○ No
SS# _____	DOB: _____	Gender Identification: Male Female Non-binary		
5. _____	_____	○ Add ○ Remove	○ Medical ○ Dental ○ Vision	○ Yes ○ No
SS# _____	DOB: _____	Gender Identification: Male Female Non-binary		
6. _____	_____	○ Add ○ Remove	○ Medical ○ Dental ○ Vision	○ Yes ○ No
SS# _____	DOB: _____	Gender Identification: Male Female Non-binary		

*If yes Other Health Insurance, please provide Coordination of Benefits information to Aetna through the Aetna Navigator website (www.aetna.com) to expedite claims processing.

Life Insurance Beneficiary Information: If no beneficiary is designated, or if the designated beneficiary does not survive the insured person, any policy death benefits will be paid to the surviving spouse, or if none, to the surviving child or children, in equal amounts, or if none, to the executor of the estate.

Beneficiary name: _____ Relationship: _____

Address: _____

IMPORTANT Opt-Out Information

I understand that by electing the Decline option for Medical, Dental and/or Vision Coverage I will have **no** coverage under the Diversified Communications Group Health Plan for the Plan Year (January 1 – December 31). The Diversified Communications Group Health Plan will not pay any medical, dental and/or vision claims incurred by me or my dependents (if any) during the Year (01/01-12/31). I understand that the only way I may elect Medical, Dental or Vision coverage under the Group Health Plan is if I have a qualified Family Status Change Event and I apply to change my coverage within 30 days of the event.

Signature and Authorization: I elect the coverage options listed on this form for the current Plan Year.
I have read the explanation of my Diversified Communications Benefits Options and authorize the choices I have made, plus any pre-tax payroll deductions required to pay for these elections.
I understand that the choices I have made will remain in effect throughout the current plan year and cannot be changed unless I have a qualifying Family Status Change and request a change within 30 days of this event.
I certify that the information I have provided above is accurate as of the date I signed this election form. I understand that any elected FSA funds or Dependent Care Reimbursement Account funds is a "use it or lose it" and any funds not reimbursed to me for eligible expenses incurred in plan year will be forfeited back to the Diversified Communications Group Health Plan.

Signature: _____ Date: _____