Wespath
BENEFITS | INVESTMENTS

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wespath.org

Choose one: ❑ HealthFlex ❑ OneExchange

HealthFlex and OneExchange Enrollment/Change Form

New hires and newly eligible participants must provide complete information on each eligible dependent. Enrolled participants making changes should provide only the information that has changed. If you wish for your mail to go to a different address, please see Part 10.

Part 1 – Participant/Plan Sponsor Information

Applicant name _____ Social Security # _____

Legal address _____ Primary phone # _____

_____ Alternate phone # _____

E-mail address _____

Marital status: ❑ Single ❑ Divorced ❑ Civil Union/ Domestic Partnership[1] ❑ Married ❑ Widowed

Effective date of marital status _____

Conference/Plan Sponsor/Employer(s) _____ Employer(s) # _____

Membership: ❑ Clergy ❑ Lay

Date of hire _____

Appointment/Employment status _____ Status effective date _____

Last day worked _____

Percentage of employment: ❑ Quarter-time ❑ Half-time ❑ Three-quarters-time ❑ Full-time[2]

Employment category: ❑ Salaried *(for Lay Employees)* ❑ Hourly

[1] This applies to same-sex civil union partners or legal domestic partners of lay employees in states that have established civil unions or comprehensive state domestic partnerships if the plan sponsor has elected to provide such coverage through Exhibit D to its adoption agreement.

[2] In accordance with the Affordable Care Act (ACA, i.e., the federal health care reform law), employers with 50 or more full-time or full-time equivalent employees (collectively, "FTEEs") are required, under the Employer Shared Responsibility Rule, to offer coverage to at least 95% of their full-time employees working 30 or more hours (e.g., ¾-time clergy) or else pay a penalty if any of those full-time employees receives a premium tax credit from a Health Insurance Marketplace. Please contact your conference benefits office or human resources office for more information or if you have any questions.

Part 2 – Processing Event

Please check the processing event below. Event effective date _____

Life Status Event	Event Name	Life Status Event	Event Name
New Enrollment	☐ New hire ☐ Newly eligible ☐ New dependent ☐ Divorce ☐ Spousal death ☐ Spouse loses other coverage	Death	☐ Participant death ☐ Retiree death ☐ Dependent death
		Termination	☐ Declines coverage ☐ Non-payment ☐ Participant losing eligibility
Add Dependent for Covered Participants	☐ Dependent loses other coverage ☐ New dependent	Other	☐ Annual election ☐ Conference transfer ☐ Continuation ☐ Divorced spouse/legal decree ☐ OneExchange ☐ New retiree ☐ Regaining eligibility/same plan year ☐ Retiree to active ☐ Retiree—no change ☐ No longer eligible for Medicare Secondary Payer Small Employer Exception (MSPSEE) ☐ Other _____
Delete Dependent for Covered Participants	☐ Dependent child ineligible ☐ Dependent gains other coverage ☐ Divorce		

Please list any special notes regarding the event:

_____

_____

_____

_____

Part 3 – Dependent Information

- List yourself and all eligible dependents, including your spouse[1], even if you are declining coverage. If you are currently enrolled and are adding/removing a dependent, list only that dependent's information.
- Indicate whether you wish to cover yourself, your spouse and/or dependent children. ***Important:*** *If you do not choose "yes" or "no" under the* ***Cover*** *column for each dependent listed, we will assume you* ***do not*** *want to cover that dependent(s) in HealthFlex.*
- Use Part 11 to provide information on additional dependents.

Name	Social Security #	Birth Date	Relationship	Gender		Disabled		Cover	
				F	M	Yes	No	Yes	No

Part 4 – Elections (Active Employees and Pre-65 Retirees[3])

Medical	*Vision*	*Dental (if applicable)*
❑ PPO B1000/P1	❑ Vision Exam Core	❑ Dental PPO
❑ PPO B1000/P2	❑ Vision Full Service	❑ Dental Passive PPO 1000
❑ CDHP C2000/P2	❑ Vision Premier	❑ Dental Passive PPO 2000
❑ CDHP C3000/P2		❑ None
❑ HDHP H1500/P3		
❑ HDHP H2000/P4		
❑ HDHP H3000/P5		

❑ Medical Reimbursement Account (if applicable) $_____ *(annual amount)*

❑ Dependent Care Account (if applicable) $_____ *(annual amount)*

❑ Health Savings Account (HSA) personal contribution (if applicable/eligible) $ _____ *(annual amount[4])*

To enroll into a HSA and to receive the HSA plan sponsor contribution and/or make personal contributions to your HSA, you must attest to the following:

❑ I have read, understand, and accept the eligibility rules of a Health Savings Account (HSA) and I confirm that I am eligible for an HSA.

❑ I have read, understand, and accept the Terms and Conditions of the *HSA Bank Disclosure Form,* the *Certification and HSA Adoption Agreement*, and the *Custodial Account Agreement*.

To decline the HSA, you must check the statement below:

❑ Although I have elected a High-Deductible Health Plan (HDHP), I elect to waive the HSA. By waiving the HSA, I acknowledge that I will not receive the HSA plan sponsor contribution and I will not be able to make personal contributions into an HSA.

[3] Pre-65 retirees are not eligible to contribute to a Medical Reimbursement Account and/or Dependent Care Account. In addition, they cannot make personal pre-tax contributions to a Health Savings Account.

[4] This amount does not include the HSA plan sponsor contribution or any excess defined contribution that will be added to your HSA. Please keep this in mind so you do not elect more than the HSA Annual Contribution Limit established by the Internal Revenue Service (IRS).

Notes:
- Pharmacy, Exam Core vision and behavioral health coverage is included with your medical election.
- If waiving HealthFlex coverage, your Plan Sponsor must complete a *HealthFlex Mandatory Coverage Waiver Form*.

Part 5 – Election to Deduct Health Plan Contributions

(Optional—Only for participants receiving retirement or disability benefits)

Complete this section for participants who currently receive monthly retirement or disability benefit payments from plans administered by Wespath Benefits and Investments (Wespath). These participants may elect to pay their HealthFlex contributions for themselves and/or their dependent(s) via a deduction from their benefit payments.

Note: Deduction from retirement or disability benefit for health plan contribution applies only to participants and/or dependents covered through HealthFlex; it does not apply to OneExchange coverage.

❑ **Initial Deduction**

Amount to be deducted per month $_____ Effective date _____

The amount indicated above will be deducted from the benefit payment I receive from one or more of the following plans: Clergy Retirement Security Program [CRSP, including the Ministerial Pension Plan (MPP) and Pre-82 Plan], United Methodist Personal Investment Plan (UMPIP), Comprehensive Protection Plan (CPP), Basic Protection Plan (BPP), and/or Retirement Plan for General Agencies (RPGA).

❑ **Change in Deduction**

Change from $_____ per month to $_____ per month Effective date _____

The new amount will be deducted from the benefit payment I receive from one or more of the following plans: CRSP, UMPIP, CPP, BPP and/or RPGA.

❑ **Not Applicable**

Note: When a death occurs, deductions are automatically stopped and will not be transferred to the surviving spouse's record. A new election form for the surviving spouse must be received by Wespath to deduct HealthFlex contributions from the surviving spouse's retirement benefit.

Part 6 – OneExchange/Health Reimbursement Account (HRA) Amount
(Post-65 Retirees and Medicare-Eligible Disabled Participants)

❑ I am *electing* OneExchange for myself and/or any eligible dependents.

❑ I am *declining* OneExchange for myself and/or any eligible dependents.

HRA Plan Sponsor-Provided Amount: Participant $ _____ Spouse/Dependent $_____
(Please enter annual amount. OneExchange will prorate for partial years.)

Note: The HRA is not provided to participants approved for the Medicare Secondary Payer Small Employer Exception and to participants in OneExchange due to Medicare disability.

Part 7 – Declination of Coverage

If you are declining to cover yourself or any eligible dependents, it is important you understand certain plan rules. By declining coverage, you are declining coverage for the balance of the current plan year, and all subsequent plan years unless you enroll for such coverage during a subsequent annual election period for coverage commencing on the following January 1. Also, any persons for whom coverage is being declined will be subject to late entrant provisions under the plans. In certain circumstances, you may be able to enroll for coverage for yourself or eligible dependents prior to a subsequent annual election period. These circumstances include marriage, birth, adoption or legal guardianship, or loss of other health insurance as provided under the Health Insurance Portability and Accountability Act of 1996 and change of status rules under HealthFlex.

Please make sure to check with your Plan Sponsor regarding the consequences and rules for declining health coverage as a retired participant.

Part 8 – Participant Signature

I attest that the participant information is true to the best of my knowledge. In addition, if I am an active participant, I have received, read and I understand the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Special Enrollment and Change of Status Event Provisions and the HealthFlex Notice of Privacy Practices, which are included in my New-Hire Enrollment Kit.

If I am declining coverage, I hereby acknowledge I read, understand and accept the rules listed in Part 7 of this form.

If I am an actively employed participant, I authorize my Salary-Paying Unit to make the appropriate pre-tax payroll deductions from my wages to apply toward my HealthFlex required contributions.

If I am receiving retirement or disability benefits, I authorize Wespath to deduct the amount(s) I have elected in Part 5 and apply the deductions toward payment of my required contributions or health insurance premiums (contributions) under the terms of the applicable group health plan, either HealthFlex or, as agreed upon between Wespath and annual conference, the health plan maintained by the annual conference. I also authorize Wespath to make changes to these deductions based on any changes in contribution amount due to election changes or otherwise. I acknowledge that I am agreeing to release Wespath, its constituent corporations, directors, officers, attorneys and employees from liability to me, my spouse, my alternate payee, my heirs, named beneficiaries, or successors in interest, for any damages which result from any action or omission taken in reliance on this instrument.

Participant signature _____ Date _____

Part 9 – Plan Sponsor Authorization

Plan sponsor signature _____ Date _____

Part 10 – Preferred Mailing Address[5]

Mailing address _____

[5] If you are receiving retirement benefits and your state of residence for tax purposes is different than your mailing address, you must complete a *State Income Tax Withholding* form. Please contact Wespath for this form.

Part 11 – Additional Dependents

Name	Social Security #	Birth Date	Relationship	Gender		Disabled		Cover	
				F	M	Yes	No	Yes	No

Note: You can access a *Summary of Benefits and Coverage (SBC)*, which summarizes important information about any health coverage option offered by your plan sponsor. The SBC is available at **www.wespath.org**; log into **HealthFlex/WebMD**, select "**HealthFlex Plan Benefits**," and search under "**Reference Center**." A paper copy is also available, free of charge, by calling **1-800-851-2201**.