

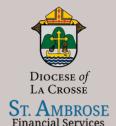
EMPLOYER & PARTICIPANT INFORMATION

CHANGE FORM QUALIFYING EVENT LAY BENEFITS

MBROSE Il Services	EMPLOYER NAME	LOCATION #	GROUP # L06588
	(PARISH - SCHOOL - INSTITUTION)	DOL	SAFS USE ONLY: EFFECTIVE DATE
rticipant Nam			lomo
	First Name	M.I. Last N	name
QUALIFYI	NG EVENT: PLEASE SELEC	CT ONE	
Ai	fter selecting a qualifying event, con	mplete the following po	ages as needed
Open Enr	ollment - Please complete the fo	llowing page	
Reductio	n of Hours - Please ONLY comp	lete participant inform	nation on the following page
	New Hours per Week	Start Da	te of New Schedule
Increase	of Hours - Please complete the f	following page	
	New Hours per Week		ite of New Schedule
Marriago	Diagon complete the following po		
Mairiage	Date of Wedding	ction Choice	Date of Month Wedding Wedding Wedding
Loss of C	overage - Please complete the fo	llowing page & submit s	support documents to SAFS
	Reason	Last Day	y of Coverage
Divorce -	Please complete the following page	;	
	Date of Divorce Decree		
Birth of a	Child - Please complete the follo	wing page	
	Date of Birth		
Terminat	ion - Please ONLY complete partic	inant information on th	ne following nage
	Resignation Date		y of Work
Now Eliai	blo Coverage - Places service	to the following name	
new Eligi	ble Coverage - Please comple 1st Day of New Eligible Covera		
	iot zay of from Engine Govern	- -	

PLEASE NOTE: Open enrollment for the "Market Place" or your spouse's benefits plan does NOT qualify as New Eligible Coverage.

Please contact St. Ambrose Financial Services for assistance navigating this situation.



EMPLOYER & PARTICIPANT INFORMATION

QUALIFYING EVENT CHANGE LAY BENEFITS

CROSSE MBROSE rial Services	EMPLOYER NAME		L	LOCATION #		GROUP # L06588		
tial Services	(PARISH - SCH	100L - INSTITUTI	ON)	DOL		SAFS US	SE ONLY: EFF	ECTIVE DATE
PARTICIPA	NT INFOR	RMATION				REQUIRED FO	R ALL PAYROL	L EMPLOYEES
First Name	M.I.	Last Name		Phone	Number	Social \$	Security Nu	mber
Address		City	State Z	ip Code	Perso	onal Email		
Birth Date Male Fem	ale Single Marrie		e Full Time Part T nd School Year School		Title		1st Day of Work	Hours per Week
BENEFIT EI	ECTIONS			ONE	FROM E	ACH EL	ECTION	I
Medical Coverage Single Family Waive Don't Qualify'() Wo	rk less than 30 hrs)	Medical Plan (Skip if Waiving or Don't Qual Traditio High De "The Ma	nal ductible HSA	(Included w	n Coverage vith Medical; skip if not Enr Single Family Waive Don't Qua	olling in Medical) alify*(I Work less than		Single Family Waive Don't Qualify "() Work less than 30 h
First Name	M.I. Last Name	е	Relationship	Gender	Birthdate	Social Sec	urity Numbe	Enrollment
								Medical Vision Dental
								Medical Vision Dental
								Medical Vision
								Dental Medical Vision
								Dental Medical
								Vision Dental Medical
								Vision Dental
OTHER INSU	date, will there be		-	u or any dej sy - Group Nu		above? If Yes		lete below. y Vision Dental
		Dependents Cove	red: First & Last Nar	ne - One Den	endent ner Boy			
		Dopondonts cove		Эне вер	S. AGENT POT BOX			
		Medical Pol	ease - Accepta	nce - Aut	horization			
r authorize any doctor, ho ccluding genetic informat RSTAND THE FOLLOWING n is to commit fraud that n selected from my paycher yself or my dependents in age, birth, adoption, or pla I certify the above is true Life Insurance Plans. By n	on and family hist : This form will be nay be punishable ck. If I am declining this plan. I must re acement for adopt and correct and ac	company, employer cory, for claims to D used for benefit in under law. This for g enrollment for my equest enrollment ion, I may be able to cknowledge I have I	, or organization iocesan Third Pa formation. The ii rm will be used a self or my deper within 31 days af o enroll myself o peen given the o	to release arty Administry Administry and author adents becater the other my dependenties:	any informatior strator. A copy listed above is ization to deduase of other greecoverage endents, provided to enroll in the I	of this author correct and tr ct my contribu oup health co ls. In addition, I that I reques Diocese of La	rization shall be rue. To verify i ution (if any) fo verage, I may, , if I have a new t enrollment w Crosse Group I	e valid as the ori ncorrect inform or the cost of the in the future, be dependent as a ithin 31 days aft Health, Vision, I

Participant Signature - Required

Date