Wespath

1901 Chestnut Avenue
Glenview, Illinois 60025-1604
wespath.org

Submit completed form to Shawn-Marie Riley. DO NOT submit directly to Wespath/HealthFlex.

Choose one: ❑ New Enrollment ❑ Existing Enrollment

HealthFlex New Enrollment or Change Form - 2027

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.

Part 1 – Participant/Plan Sponsor Information

Participant name _____ _____ _____
First Middle Last

Participant # _____

Mailing address _____

Social Security # _____
(Last 5 numbers unless new enrollment)

_____

Primary phone # _____

E-mail address _____

Alternate phone # _____

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

Effective date of marital status _____

Conference/Plan Sponsor/Employer	Employer #	Date of Hire	Appointment/ Employment Status	Status Effective Date	Last Day Worked	Weekly Hours
Horizon TX/	335524/					
(Enter Church Name Above)	(Enter Church # Above)					

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 ❑ New Retiree ❑ Regaining eligibility/same plan year ❑ Retiree to active ❑ 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 – Participant and Dependent Information

- List participant ***and*** all eligible dependents, including spouse[1], even if declining coverage. If participant is currently enrolled and adding/removing a dependent, list only that dependent's information.
- Indicate whether or not each individual will be covered. ***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 8** to provide information on additional dependents.

Name	Social Security #	Birth Date	Relationship	Sex		Disabled		Cover					
								Medical		Dental		Vision	
				F	M	Yes	No	Yes	No	Yes	No	Yes	No
			Self										
First Middle Last													
First Middle Last													
First Middle Last													
First Middle Last													
First Middle Last													

Part 4 – Elections (Active Employees and Pre-65 Retirees[2])

Medical/Pharmacy	Vision	Dental (if applicable)
❑ B1000	❑ Vision Exam Core	❑ Dental PPO
❑ C2000 with HRA	❑ Vision Full Service	❑ Dental Passive PPO 2000
❑ H2000 with HSA	❑ Vision Premier	❑ DHMO
❑ H5000 with HSA	❑ None	❑ None
❑ None*		

Notes:
- If no boxes are checked, any individuals who are covered in Part 3 will be enrolled in the default plans.
- Pharmacy, Exam Core vision (unless waived) and behavioral health coverage is included with every medical election.
- None*—If waiving HealthFlex coverage, Plan Sponsor must complete a *HealthFlex Mandatory Coverage Waiver Form*.

❑ Health Care Flexible Spending Account (FSA) (if applicable) $_____ *(prorated annual amount[4])*
❑ Dependent Care FSA (if applicable) $_____ *(prorated annual amount[4])*
❑ Health Savings Account (HSA) personal contribution (if applicable/eligible) $_____ *(prorated annual amount[3])*

- To enroll into a HSA and to receive the HSA plan sponsor contribution and/or make personal contributions to the HSA, participant 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 HealthEquity Terms of Use, the Card Holder Agreement and Custodial Agreement.
- To decline the HSA, participant must check the statement below:
  - ❑ Although I have elected an HSA Plan, 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.

Regulatory Mailing Preference Election

If you agree to delivery of annual health plan legal and regulatory notices (i.e., notices that explain certain rights and requirements under Medicare Part D, Medicaid/Children's Health Insurance Program, Women's Health and Cancer Rights Act, and the HIPAA Notice of Privacy Practices) by email from Wespath, please note that you have the right to request and receive a paper copy at no cost. You can request a paper copy by contacting the Wespath Active Benefits Team at 1-800-851-2201 or emailing at activeteam@wespath.org. Your election to receive these notices by email will remain in place unless you withdraw it. You may withdraw your consent to receive notices electronically at any time by contacting the Wespath Active Benefits Team. If you withdraw this consent, notices will be sent to you via U.S. mail. You may also update your email address at any time with Wespath by updating your information in Benefits Access or contacting Wespath. If we receive notification a notice could not be delivered electronically (i.e., email was undeliverable), Wespath will mail the notice to the address we have on file for you. Additionally, we will opt you out of electronic delivery for regulatory notices. You can elect to receive notices electronically again at any time by contacting the Wespath Active Benefits Team or during Annual Election.

❑ I elect to receive regulatory mailings by email
❑ I elect to receive regulatory mailings by US mail

Part 5 – Declination of Coverage Information for Participants

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 6 – 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 unenrolling in HealthFlex coverage to enroll in a health plan through the Affordable Care Act Marketplace/ Exchange, I attest that the individuals I have unenrolled have or will enroll in such health plan effective no later than the day immediately following the last day of HealthFlex coverage.

If I am declining coverage, I hereby acknowledge I read, understand and accept the rules listed in Part 5 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 applicable.

Participant signature _____ Date _____

Part 7 – Plan Sponsor Authorization

Plan sponsor signature _____, Conference Benefits Administrator Date _____

Part 8 – Additional Dependents

Name	Social Security #	Birth Date	Relationship	Sex		Disabled		Cover					
								Medical		Dental		Vision	
				F	M	Yes	No	Yes	No	Yes	No	Yes	No
First Middle Last													
First Middle Last													
First Middle Last													
First Middle Last													
First Middle Last													

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 SBCs (one for each plan option) are available at **benefitsaccess.org**; log in and select the **Health** tab across the top, then select **Manage Health Benefits**, and click **View Your Benefits** to access the health benefits site. Under **ITEMS TO EXPLORE**, click **Resources**. Under **Documents and Resources**, you will find a list of all documents available, including the **Summary of Benefits and Coverage (SBC)**. A paper copy is also available, free of charge, by calling **1-800-851-2201**.

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

[3] This amount does not include the HSA plan sponsor contribution or any excess defined contribution that will be added to the HSA. Please keep this in mind to avoid exceeding the HSA Annual Contribution Limit established by the Internal Revenue Service (IRS).

[4] This amount cannot be less than what you have contributed to date through HealthFlex. In addition, this amount will be prorated and billed based on the number of months remaining in the plan year.

If you are **NOT** completing this document online, please complete it and return to Wespath by one of the following methods:

- E-mail (scanned copy) to **activeteam@wespath.org** or
- Fax to **1-847-866-5195** or
- Mail to Wespath
  Customer Solutions
  1901 Chestnut Avenue, Glenview, IL 60025

Be sure to keep a copy for your records.

This form includes and/or is requesting personally identifiable information (PII) and/or protected health information (PHI). You are encouraged to make elections and beneficiary designations online at **benefitsaccess.org**. When possible, managing your benefits online is the recommended approach to keep your PII and PHI safe and secure.