FLEXIBLE BENEFITS ENROLLMENT CHANGE FORM

BIRTH/ADOPTION

To minimize delays in processing your packet, and possible large deductions *from your paycheck due to missed premiums please return all required forms along with required documentation by the due date enclosed.*

If you do not return the forms and documentation that is required, no changes will be made to your benefits *and you will have to wait until the next open enrollment period or another qualified status change event that allows you to add dependents and/or make changes.*

You will receive a Benefits Confirmation at your home address once your benefit forms have been processed. If you have any questions, please do not hesitate to contact the ***HR Service Center at 1-800-543-4654.***

REQUIRED DOCUMENTATION

* **For Birth:** copy of child's birth certificate or hospital record naming the employee as the child's parent.

* **For Adoption:** copy of the certified adoption paperwork naming you and/or your spouse as the adopted parent.

You may **add** your dependent to your current healthcare plans.

You may **elect or increase** Accidental Death and Dismemberment (AD&D) Insurance.

You may **elect or increase** your Supplemental Life Insurance by 1x annual salary.

You may **elect the next level** of coverage for Dependent Life Insurance**.**

You may **elect or increase** your Health Care FSA or Dependent Day Care FSA.

If you do not return the forms and documentation that is required, no changes will be made to your benefits *and you will have to wait until the next open enrollment period or another qualified status change event that allows you to add dependents and/or make changes.*

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IMPORTANT BENEFIT INFORMATION

The FirstRewards Website at www.myfirstrewards.com is your primary source of information about your health and other group benefits. You can also link directly to your healthcare providers from this site.

Please return your packet with required documentation by the due date on the form to the appropriate location below.

If you work in OH return to this location:	**If you do not work in OH return to this location:**
Attn: HRSC A-GO-7 FirstEnergy Corp 76 South Main Street Akron OH 44308 or Interoffice Mail: HRSC, A-GO-7 Fax #: 330-761-2314	Attn: HRSC R-REAP-51 FirstEnergy Corp 2800 Pottsville Pike P O Box 16001 Reading PA 19612 or Interoffice Mail: HRSC, R-REAP-51 Fax #: 330-315-9220

FLEXIBLE BENEFITS ENROLLMENT CHANGE FORM

EMPLOYEE INFORMATION			
SAP NO.:	**SOCIAL SECURITY NO.**	**HOME PHONE NO.**	**SEX** ☐ **MALE** ☐ **FEMALE**
EMPLOYEE'S NAME: (Last, First, Middle Initial)			**DATE OF BIRTH** (MM, DD, YYYY)
EMPLOYEE'S ADDRESS:			

If birth or adoption date is more than 31 days from today's date, do not complete this form.
Contact the HR Service Center at 1-800-543-4654 for assistance.

Date of Birth or Adoption:	
Effective Date of Benefits:	**Date of Birth or Adoption**
Return by Due Date:	**Within (31 days) from child's date of birth or date of adoption.**

REQUIRED DOCUMENTATION TO ADD DEPENDENT

BIRTH – Copy of child's **birth certificate** -**OR-** Copy of **hospital record** naming the employee as the child's parent.

ADOPTION – Copy of the **certified adoption paperwork** naming you and/or your spouse as the adopted parent.

Please fill in the child's information below and check the plans you wish to add dependent.

CHILD'S NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX	DISABLED
			☐ M / ☐ F	☐ Y / ☐ N

*Please select which plans you wish to add your dependent listed above**:** ☐ **Medical/Rx** ☐ **Dental** ☐ **Supplemental Vision**

CHILD'S NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX	DISABLED
			☐ M / ☐ F	☐ Y / ☐ N

*Please select which plans you wish to add your dependent listed above**:** ☐ **Medical/Rx** ☐ **Dental** ☐ **Supplemental Vision**

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE PLAN – (Axis Capital)

Skip this section (If you do not wish to make changes). You may increase accidental death and dismemberment insurance.

Check Level of Coverage	Coverage Tier	Rate
☐	**Employee Only**	$.018 / $1000 of coverage
☐	**Employee & Spouse / Domestic Partner**	$.030 / $1000 of coverage
☐	**Employee & Child(ren)**	$.021 / $1000 of coverage
☐	**Family**	$.036 / $1000 of coverage

Options: 1-10 times annual base salary.

☐ One (1) times annual base pay	☐ Six (6) times annual base pay
☐ Two (2) times annual base pay	☐ Seven (7) times annual base pay
☐ Three (3) times annual base pay	☐ Eight (8) times annual base pay
☐ Four (4) times annual base pay	☐ Nine (9) times annual base pay
☐ Five (5) times annual base pay	☐ Ten (10) times annual base pay (maximum)

FLEXIBLE BENEFITS ENROLLMENT CHANGE FORM

DEPENDENT LIFE INSURANCE PLAN – (MetLife)

Skip this section (If you do not wish to make changes). You may increase to the next level of coverage, *however if you are married you will be required to complete proof of insurability form for your spouse*, forms will be mailed to you once your benefit packet has been received, no changes will be made for dependent life, pending approval from MetLife.

Please check your marital status: ☐ Married ☐ Not Married

☐ **Standard Level -** After-tax Cost: $2.39/month (Standard Level $10,000 Spouse; $5,000 each Child)

☐ **High Level -** After-tax Cost: $4.68/month (High Level $20,000 Spouse; $10,000 each Child)

☐ **Premier Level -** After-tax Cost: $9.36/month (Premier Level $40,000 Spouse; $20,000 each Child)

SUPPLEMENTAL LIFE INSURANCE PLAN – (MetLife)

Skip this section (If you do not wish to make changes). You may elect or increase your Supplemental Life Insurance by 1 level of coverage (1x annual salary). **NOTE: Evidence of insurability is required for supplemental life insurance amounts equal to or greater than $1 million or if you elect supplemental life insurance for the first time**. An evidence of insurability form will be sent to you. If approved, coverage will take effect the first of the month following approval (Maximum coverage amount of $5M)

Multiple of pay: Please indicate **total** amount of supplemental coverage (check one box)

☐ One (1) times annual base pay	☐ Six (6) times annual base pay
☐ Two (2) times annual base pay	☐ Seven (7) times annual base pay
☐ Three (3) times annual base pay	☐ Eight (8) times annual base pay
☐ Four (4) times annual base pay	☐ Nine (9) times annual base pay
☐ Five (5) times annual base pay	☐ Ten (10) times annual base pay (maximum)

FLEXIBLE SPENDING ACCOUNTS – (WageWorks)

Skip this section - If you do not wish to make changes. You may ***increase*** your Flexible Spending Accounts. Please indicate your annual before-tax election amount(s) separately below.

☐ **Health Care FSA** (Cannot elect if enrolled in HDHP)
Annual before-tax election _____ **(min. $26 - max. $2,600 per family)**

☐ **Limited FSA** (For HDHP participants only) *Note: Funds can be used for dental and vision expenses only*
Annual before-tax election _____ **(min. $26 - max. $2,600 per family)**

☐ **Dependent Day Care FSA** (For child/adult day care services only)
Annual before-tax election _____ **(min. $26 - max. $5,000 per family)**

FLEXIBLE BENEFITS ENROLLMENT CHANGE FORM

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SIGNATURE/AUTHORIZATION AND AGREEMENT

NOTICE TO ALL EMPLOYEES COMPLETING THIS FORM:

It is fraudulent to fill out this form with information you know to be false, or to omit important information. Dismissal from employment, criminal and/or Civil penalties can result from such acts. By my signature below, I authorize the Company to deduct from my paycheck the amount required for the coverage that I have selected, if any. I also understand that, if I elect to opt-out of health care coverage and/or the Flexible Spending Account(s), I can only re-enroll during a future open enrollment period, unless I have a qualified status change. **The above is not a contract or guarantee of any kind. The benefits and programs described are subject to modification or termination by the company at any time and without notice.**

EMPLOYEE SIGNATURE: ***SAP #:*** ***DATE:***

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