Non-Barg Employees
Employee Loss Coverage Packet – QSC Portal Packet

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

January 22, 2018

EMPLOYEE LOSS COVERAGE

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 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

Letter, Document, or Notice from where coverage is being terminated (business, old employer, healthcare provider, etc.) letter must include employee's name, and dependent(s) if applicable, date coverage terminated **or** a HIPAA certificate verifying the date coverage terminated and names of whom were terminated.

ADDITIONAL VERIFICATION REQUIRED IF ADDING DEPENDENT(S)

NOTE: Only eligible dependents that are losing coverage can be added during this qualified status change, verification of those that lost coverage must be provided.

- ***To add spouse***, please provide a copy of your marriage certificate and Spouse/Domestic Partner Coverage Verification Form
- ***To add domestic partner*****,** a declaration of domestic partner form with required documents and Spouse/Domestic Partner Coverage Verification Form
- ***To add your child (ren) up to age 26yrs*****,** please provide a copy of the birth certificate naming the employee or spouse as the child's parent or appropriate court order/adoption decree naming you and/or your spouse as the child's legal guardian.

(See attached dependent eligibility verification requirements)

IMPORTANT BENEFIT INFORMATION

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

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FirstEnergy

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EMPLOYEE INFORMATION			
SAP #	**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:			

EMPLOYEE LOSS COVERAGE	
Date Employee Loss Coverage:	
Effective Date Of Benefits:	1st of the following month of the date the employee loss coverage
Return By Due Date:	**Within (31 days) from the date the dependent loss coverage**

REQUIRED DOCUMENTATION:

Letter, Document, or Notice from where coverage is being terminated (business, old employer, healthcare provider, etc.) letter must **include employee's name**, and dependents name if applicable, letter must also include the **date coverage terminated or** a HIPAA certificate verifying the date coverage terminated and names of whom were terminated.

ADDITIONAL VERIFICATION REQUIRED TO ADD DEPENDENTS

- To add spouse, please provide a copy of your marriage certificate and Spouse/Domestic Partner Coverage Verification Form
- To add domestic partner, a declaration of domestic partner form with required documents and Spouse/Domestic Partner Coverage Verification Form
- To add your child (ren) up to age 26yrs, please provide a copy of the birth certificate naming the employee or spouse as the child's parent or appropriate court order/adoption decree naming you and/or your spouse as the child's legal guardian.

NOTE: Only dependents that are losing coverage can be added during this qualified status change, verification of those that lost coverage must be provided.

LIST ELIGIBLE DEPENDENT(S) INFORMATION BELOW

Name of Dependent	(SP) Spouse (DP) Domestic Partner (DP) Child (C)	Date of Birth	Social Security Number	Sex (F/M)	Disabled	Please ***check*** the appropriate ***plans to add*** your ***dependent(s)***		
						Medical/Rx	**Dental**	**Vision**
	SP/ DP							
	C							
	C							
	C							

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DENTAL PLAN - (DELTA DENTAL)

☐ Waive Dental Plan	☐ Single
☐ Keep My Same Dental Plan (no change)	☐ Employee and Child(ren)
☐ Delta Dental Basic Plan	☐ Employee and Spouse/Domestic Partner
☐ Delta Dental Plus Plan	☐ Family (Employee, Spouse/Domestic Partner and Child(ren)

FIRSTENERGY - MEDICAL/PRESCRIPTION PLAN - (ANTHEM and CVS/CAREMARK)

☐ Waive Medical/Rx	☐ Single
☐ Base PPO/Base RX	☐ Employee and Child(ren)
☐ Consumer (HDHP) High Deductible Health Plan Rx included	☐ Employee and Spouse/Domestic Partner
☐ Enhanced (HDHP) High Deductible Health Plan Rx included	☐ Family (Employee, Spouse/Domestic Partner and Child(ren)
Health Savings Account (HSA) Annual Voluntary Contribution $_____	

If you elect the FirstEnergy Anthem Consumer or Enhanced HDHP/Rx Plan you are eligible to contribute to an HSA.
Please see the chart below to verify the amount you are eligible to contribute.

Medical HDHP Health Savings Account – (HealthEquity)

*If your benefits start on:	and you elect single medical coverage, you can contribute up to the below amount in your HSA:	and you elect two-person or family medical coverage, you can contribute up to the below amount in your HSA:
Jan. 1, 2018	$3,450.00	$6,900.00
Feb. 1, 2018	$3,162.50	$6,325.00
Mar. 1, 2018	$2,875.00	$5,750.00
Apr. 1, 2018	$2,587.50	$5,175.00
May 1, 2018	$2,300.00	$4,600.00
Jun. 1, 2018	$2,012.50	$4,025.00
Jul. 1, 2018	$1,725.00	$3,450.00
Aug. 1, 2018	$1,437.50	$2,875.00
Sep. 1, 2018	$1,150.00	$2,300.00
Oct. 1, 2018	$862.50	$1,725.00
Nov. 1, 2018	$575.00	$1,150.00
Dec. 1, 2018	$287.50	$575.00

VISION PLAN – (VSP)

I ELECT THE FOLLOWING OPTION	I ELECT THE FOLLOWING DEPENDENT COVERAGE LEVEL
☐ Waive Supplemental Vision Coverage	☐ Single
☐ Supplemental Vision Plan	☐ Employee and Child(ren)
	☐ Employee and Spouse/Domestic Partner
	☐ Family (Employee, Spouse/Domestic Partner and Child(ren)

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FLEXIBLE SPENDING ACCOUNTS – (WageWorks)

Please indicate your annual before-tax election amount(s) separately below. Annual election limits of $26 minimum. Your annual election amount(s) will be deducted in equal amounts from your pay.

To determine the amount that will be withheld from your pay, divide the annual election amount(s) by the number of remaining pay periods.

☐ **Health Care FSA** Annual before-tax election _____ (max. $2,600 per family)

☐ No Change/Keep Same

☐ Waive

NOTE: You cannot elect if enrolled in High Deductible Healthcare Plan (HDHP)

☐ **Dependent (Day Care) FSA** Annual before-tax election _____ (max. $5,000 per family)

☐ No Change/Keep Same

☐ Waive

NOTE: Dependent Day Care FSA is for eligible dependent child/adult daycare services

☐ **Limited FSA** Annual before-tax election _____ (max. $2,600 per family)

☐ No Change/Keep Same

☐ Waive

NOTE: For HDHP plan participants only. Limited FSA can only be used for dental and vision services

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.

PARTICIPANT SIGNATURE:	DATE SIGNED:
SAP NO.:	EFFECTIVE DATE:

Please make an election for all plans even if waiving plans. All enrollment forms must be completed and returned.

If you **work in OH** return forms to this location:	If you **do not work in OH** return forms to this location:
Attn: HRSC A-GO-7 FirstEnergy Corp 76 South Main Street Akron OH 44398 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 BENEFIT ENROLLMENT/CHANGE FORM

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Affidavit of Spousal Health Care Coverage

This form is applicable to both spouses and domestic partners ("spouses") of FirstEnergy employees.

FirstEnergy Employee: _____ Spouse: _____

FirstEnergy Employee SAP #: _____

Important: Please ensure this form is fully completed. Your response, or lack of response, will impact your spouse's health care coverage.

SECTION I: Spouse Employment Information

Is your spouse currently employed?

□ Yes (continue to Section II) □ Employed by FirstEnergy (continue to Section III)

□ Self-employed (continue to Section III) □ Not employed/Retired (continue to Section III)

If your spouse is working at least 32 hours per week and is offered employer-subsidized medical and prescription drug coverage and you elect FirstEnergy healthcare coverage for your spouse, you will be charged an additional spousal premium of $200 per month. A change in qualified status throughout the year that results in your spouse not having employer-subsidized coverage permits you to add your spouse to coverage without a charge for the premium.

SECTION II: Spouse's Employer Certification of Spouse's Health Benefit Coverage

NOTE: This section must be completed in full by your spouse's employer.

1. Is the spouse listed above working at least 32 hours per week?
□ Yes □ No

2. Is the spouse currently eligible for his/her employer-subsidized medical and prescription drug coverage through your company (whether or not he/she is enrolled)? □Yes □ No

Please complete the following:

Name of employer: _____

Address of employer: _____
Number and Street City State Zip

Printed Name of Employer Representative: _____

Title of Employer Representative: _____

Signature of Employer Representative: _____

Phone: ( )_____ Date: _____

Section III: Acknowledgement – must be signed by FirstEnergy Employee named above

I certify that this information is true, correct and current. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

FirstEnergy Employee Signature *(required)*: _____ Date: _____

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

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DECLARATION OF DOMESTIC PARTNER

We, _____ and _____ each certify and declare we are
(Employee) (Domestic Partner)

domestic partners in accordance with the following criteria as of _____:
(Date)

- Are at least 18 years of age.
- Are not related to each other by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.
- Are not legally married to anyone else.
- Are not in this relationship solely for the purpose of obtaining benefits coverage.
- Have lived together for at least 12 consecutive months.
- Have an exclusive, committed relationship mutually responsible for each other's welfare demonstrated by at least three of the following: **(You must attach three documents for verification.)**
  - Common ownership of real property
  - Common ownership of a motor vehicle
  - Driver's licenses listing a common address
  - Proof of joint bank accounts or credit accounts
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner's will
  - Assignment of durable property, power of attorney, or health care power of attorney

Change in Domestic Partnership

- We understand that we have an obligation to notify FirstEnergy if there is change in our domestic partnership status as attested to in this declaration (e.g., due to a change in residence of one partner, termination of the relationship, etc.) within 31 days of such change by filing a Termination of Domestic Partnership form.

We understand that the employee will be responsible for payment of applicable income taxes as a result of FirstEnergy providing health care benefits to my domestic partner.

We understand that providing false or misleading information in this declaration may result in termination of employment and/or repayment of medical, prescription drug, dental and vision expenses.

We affirm that the statements in this declaration and the documents attached are true and correct. We certify that we are submitting this declaration as part of FirstEnergy's annual benefits enrollment period or within 31 days from the date the eligibility criteria was met.

_____ _____
Employee Signature and Date Domestic Partner Signature and Date

_____ _____
Employee Name (Printed) Domestic Partner Name (Printed)

_____ _____ _____
Employee SAP Number Domestic Partner Date of Birth Domestic Partner SSN

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DEPENDENT ELIGIBILITY

You can enroll your eligible dependents for coverage during the annual enrollment period. Your dependents include:

Legal spouse or domestic partner

Your children up to age 26 regardless if they have health care coverage available through their employer-sponsored plan, including adopted children, foster children and stepchildren.

Your unmarried children age 26 and older who are incapable of self-support due to a physical or mental disability. Proof of disability and proof that the dependent is financially dependent upon his or her parents must be provided to the administrator within 31 calendar days of the date the child would otherwise become ineligible for Plan participation. Medical updates may be required periodically. If your child is incapable of self-support, contact your carrier to complete necessary forms.

Verification of eligibility is required to enroll your eligible dependent in a FirstEnergy health plan. In order to add an eligible dependent(s) to your health care coverage, you must supply the appropriate documentation during your employee orientation session (see required dependent verification below). If verification of eligibility is not received along with the benefits enrollment form, the dependent(s) will not be added.

REQUIRED DEPENDENT VERIFICATION

Spouse: Copy of your marriage certificate.

Dependent Child: Copy of the birth certificate or the hospital record, with the name of the child's parents documented.

Stepchild: Copy of the birth certificate or the divorce decree, including the portion that states the party responsible for health care coverage.

Adopted Child: Copy of the certified adoption paperwork.

Foster Child: Copy of the certified foster care paperwork.

Domestic Partner: Complete Declaration of Domestic Partner Form and provide appropriate documentation (see attached form).

Please Note If Adding Domestic Partner: FirstEnergy will subsidize domestic partner coverage, but any cost associated with coverage of the partner will be withheld from the employee's paycheck on an **after-tax basis**, in accordance with IRS regulations. The amount withheld will be the difference in the cost of the employee-only plan and the appropriate plan to cover the domestic partner, whether it is the employee and domestic partner plan or the family plan. Once your Domestic Partner has been enrolled, you will receive a benefits confirmation which will reflect the total cost as **pre-tax.** Please review your paystubs for the correct breakdown of pre-tax and after-tax deductions.

IMPORTANT BENEFIT INFORMATION

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