Non-Bargaining/Exempt Employees
Marriage

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

MARRIAGE

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

* A copy of your marriage certificate is required to process your qualified status change.

* Please answer all three questions on the Spousal/Partner Verification Form included in the marriage form.

*Additional verification required if adding eligible dependent(s) under the age of 26yrs old. (see attached dependent verification sheet)

IMPORTANT BENEFIT INFORMATION

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.***

The FirstRewards website at www.myfirstrewards.com is your primary source of information about your healthcare plans, and other group benefits including MetLife & 401K savings beneficiary designation forms. You can also link directly to your healthcare providers from this site.

Please return forms and required documentation:

Attn: Room M156
FirstEnergy Corp
800 Cabin Hill Drive
Greensburg, PA 15601
or
Interoffice Mail: G-CH, Room M156
Fax #: 330-245-5737

Non-Bargaining/Exempt Employees
Marriage

FirstEnergy

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

EMPLOYEE INFORMATION

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

QUALIFIED STATUS CHANGE: MARRIAGE

Date of Marriage: _____ *(If marriage date was more than 31 days ago please contact the HRSC immediately!)*

Return Date: return within but no later than **(31 days)** from the date of marriage.

REQUIRED DOCUMENTATION

* A copy of your marriage certificate is required to process your qualified status change.

* Please answer all three questions on the Spousal/Partner Verification Form included in the marriage form.

*Additional verification required if adding eligible dependent(s) under the age of 26yrs old. (see attached dependent verification sheet)

Please change my name to: _____
(first name, middle initial, last name):

Spouse's Info: _____
(first name, middle initial, last name / date of birth / social security #)

**** If you are married to an FirstEnergy Employee please include spouse's sap #:***_____

DENTAL PLAN – DELTA DENTAL

I ELECT THE FOLLOWING OPTION	I ELECT THE FOLLOWING DEPENDENT COVERAGE LEVEL
☐ No Change ☐ Waive my Dental Coverage ☐ Keep my same plan (add dependents only) ☐ Basic Dental ☐ Plus Dental	☐ Single ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Family (Employee, Spouse and Child (ren)

LIST YOUR DENTAL PLAN DEPENDENT INFORMATION BELOW

(A) Add (D) Drop	NAME		DATE OF BIRTH	SOCIAL SECURITY NO.	SEX M	SEX F	
		SP			☐	☐	
		CH			☐	☐	☐ DISABLED
		CH			☐	☐	☐ DISABLED
		CH			☐	☐	☐ DISABLED

Non-Bargaining/Exempt Employees
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FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

MEDICAL & RX PLAN – (ANTHEM & CVS/CAREMARK)

IMPORTANT MESSAGE: If you are currently enrolled in HDHP, you cannot change to the Base PPO Plan. Your options would be Consumer HDHP or Enhanced HDHP.

I ELECT THE FOLLOWING PLAN OPTION	I ELECT THE FOLLOWING DEPENDENT COVERAGE LEVEL
☐ No Change ☐ Waive my Medical/Rx Coverage ☐ Keep my same plan (add dependents only) ☐ **Base PPO with Rx Base** ☐ **Consumer HDHP** with Rx *Health Savings Account* - Elect or Change HSA *Annual Voluntary Contribution Amount* $_____ ☐ **Enhanced HDHP** with Rx *Health Savings Account – Elect or Change* HSA *Annual Voluntary Contribution* Amount $_____	☐ Single ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Family (Employee, Spouse/ and Child (ren)

LIST YOUR MEDICAL PLAN DEPENDENT INFORMATION BELOW

(A) Add (D) Drop	NAME		DATE OF BIRTH	SOCIAL SECURITY NO.	SEX M	SEX F	
		SP			☐	☐	
		CH			☐	☐	☐ DISABLED
		CH			☐	☐	☐ DISABLED
		CH			☐	☐	☐ DISABLED

VISION PLAN – (VSP)

I ELECT THE FOLLOWING OPTION	I ELECT THE FOLLOWING DEPENDENT COVERAGE LEVEL
☐ No Change ☐ Waive my Supplemental Vision Coverage ☐ Supplemental Vision Plan	☐ Single ☐ Employee and Child (ren) ☐ Employee and Spouse ☐ Family (Employee, Spouse and Child (ren)

LIST YOUR VISION PLAN DEPENDENT INFORMATION BELOW

(A) Add (D) Drop	NAME		DATE OF BIRTH	SOCIAL SECURITY NO.	SEX M	SEX F	
		SP			☐	☐	
		CH			☐	☐	☐ DISABLED
		CH			☐	☐	☐ DISABLED
		CH			☐	☐	☐ DISABLED

Basic vision coverage is only offered when an employee waives his/her supplemental vision coverage, only then will employee and dependents enrolled in a medical plan be enrolled in basic vision at no cost.

Non-Bargaining/Exempt Employees
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FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

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

I elect the following

Options (Check only 1 box)

☐ Waive Coverage

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

Multiples of pay (Check only 1 box):

- ☐ One-times annual base pay
- ☐ Two-times annual base pay
- ☐ Three-times annual base pay
- ☐ Four-times annual base pay
- ☐ Five-times annual base pay
- ☐ Six-times annual base pay
- ☐ Seven-times annual base pay
- ☐ Eight-times annual base pay
- ☐ Nine-times annual base pay
- ☐ Ten-times annual base pay (maximum)

To calculate your annual cost, round your annual base pay to the next highest dollar, then multiply by the level of coverage selected above, i.e., 1 to 10 times annual base pay. This annual cost will be deducted in equal amounts from your weekly (52 payments) pay. (Maximum coverage amount of $3 Million)

DEPENDENT LIFE INSURANCE PLAN – (METLIFE)

You may increase by 1 level only

- ☐ Waive Coverage
- ☐ **No Change/Keep Same**
- ☐ **Standard Level** After-tax Cost: $2.39/month
  - $10,000 Spouse; $5,000 each Child
- ☐ **High Level** After-tax Cost: $4.68/month
  - $20,000 Spouse; $10,000 each Child
- ☐ **Premier Level** After-tax Cost: $9.36/month
  - $40,000 Spouse; $20,000 each Child

You may elect the next level of coverage. **Your spouse will need to complete an EOI (Evidence of Insurability) form, which will be mailed to your home, after you return this packet.** No changes will be made until MetLife reviews and approves the EOI.

Non-Bargaining/Exempt Employees
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FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

SUPPLEMENTAL LIFE INSURANCE PLAN – (METLIFE)

You may increase coverage by one-time base pay. Qualified life status changes throughout the year make you eligible to increase your supplemental life insurance coverage by one times base pay without providing evidence of insurability.

Note: The after-tax cost is based on the rates located on myfirstrewards.com

- Multiple of pay: Please indicate **total** amount of supplemental coverage

  * You can review your benefits confirmation to see what level you currently have, and check the next level to increase.

  ☐ Waive

  ☐ **No Change/Keep Same**

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

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)

FLEXIBLE SPENDING ACCOUNTS (WageWorks)

You may elect or increase your Flexible Spending Accounts. 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 pay periods.

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

☐ No Change/Keep Same

*** You cannot elect Health Care FSA 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

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

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

☐ No Change/Keep Same

*** Limited Health Care FSA for HDHP plan participants only. and can only be used for dental and vision services**

Non-Bargaining/Exempt Employees
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FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

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.:	

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

Please return forms and required documentation:

Attn: Room M156
FirstEnergy Corp
800 Cabin Hill Drive
Greensburg, PA 15601
or
Interoffice Mail: G-CH, Room M156
Fax #: 330-245-5737

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

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: _____

Non-Bargaining/Exempt Employees
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FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

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

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