

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

SPOUSE GAINS BENEFITS

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

Document or Letter from your Spouse's employer with open enrollment start and end dates, or effective date of benefit enrollment or benefit changes.

OR

Letter from your Spouse's employer, with dates of Open Enrollment period, letter must include domestic partner's name, effective date of benefit enrollment (changes in coverage must correspond with Spouse's Open Enrollment elections)

OR

A copy of your Spouse's Medicare card or a letter confirming Spouse's Medicare effective date. (Remove spouse only).

(Additional documentation required to add dependent(s) Please see required documentation on last page)

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.

If you **work in OH** return 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

If you **do not work in OH** return to this location:

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

EMPLOYEE INFORMATION

SAP NO.:	SOCIAL SECURITY NO.	CONTACT PHONE NO.	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
EMPLOYEE'S NAME: (Last, First, Middle Initial)			DATE OF BIRTH (MM, DD, YYYY)
EMPLOYEE'S ADDRESS:			

QUALIFIED STATUS CHANGE: SPOUSE GAINS BENEFITS

Spouse Gains Benefits: _____ (If spouse gained benefits more than 31 days ago please contact the HRSC immediately!)

Return Date: Within but no later than **(31 days)** from the date spouse gained benefits.

REQUIRED DOCUMENTATION

Document or Letter from your Spouse's employer with open enrollment start and end dates, or effective date of benefit enrollment or benefit changes.

OR

Letter from your Spouse's employer, with dates of Open Enrollment period, letter must include domestic partner's name, effective date of benefit enrollment (changes in coverage must correspond with Spouse's Open Enrollment elections)

OR

A copy of your Spouse's Medicare card or a letter confirming Spouse's Medicare effective date. (Remove spouse only).

(Additional documentation required to add dependent(s) Please see required documentation on last page)

DENTAL PLAN – (DELTA DENTAL)

I ELECT THE FOLLOWING OPTION		I ELECT THE FOLLOWING DEPENDENT COVERAGE LEVEL	
<input type="checkbox"/> Waive Dental Coverage <input type="checkbox"/> Keep my same plan (add dependents only) <input type="checkbox"/> Basic Dental <input type="checkbox"/> Plus Dental		<input type="checkbox"/> Single <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Family (Employee, Spouse and Child (ren))	

LIST YOUR DENTAL PLAN DEPENDENT INFORMATION BELOW

(A) Add (D) Drop	NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NO.	SEX		
					M	F	
		SP			<input type="checkbox"/>	<input type="checkbox"/>	
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED

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
<input type="checkbox"/> Waive Medical/Rx Coverage <input type="checkbox"/> Keep my same plan (add dependents only) <input type="checkbox"/> Base PPO with Rx Base <input type="checkbox"/> Consumer HDHP with Rx <i>Health Savings Account - Elect or Change</i> HSA <u>Annual Voluntary Contribution Amount</u> \$ _____ <input type="checkbox"/> Enhanced HDHP with Rx <i>Health Savings Account – Elect or Change</i> HSA <u>Annual Voluntary Contribution Amount</u> \$ _____	<input type="checkbox"/> Single <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Family (Employee, Spouse/ and Child (ren))

LIST YOUR MEDICAL PLAN DEPENDENT INFORMATION BELOW

(A) Add (D) Drop	NAME	SP CH	DATE OF BIRTH	SOCIAL SECURITY NO.	SEX		
					M	F	
		SP			<input type="checkbox"/>	<input type="checkbox"/>	
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED

VISION PLAN – (VSP)

I ELECT THE FOLLOWING OPTION	I ELECT THE FOLLOWING DEPENDENT COVERAGE LEVEL
<input type="checkbox"/> Waive Supplemental Vision Coverage <input type="checkbox"/> Supplemental Vision Plan	<input type="checkbox"/> Single <input type="checkbox"/> Employee and Child (ren) <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Family (Employee, Spouse and Child (ren))

LIST YOUR VISION PLAN DEPENDENT INFORMATION BELOW

(A) Add (D) Drop	NAME	SP CH	DATE OF BIRTH	SOCIAL SECURITY NO.	SEX		
					M	F	
		SP			<input type="checkbox"/>	<input type="checkbox"/>	
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DISABLED
		CH			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 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.

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

FLEXIBLE SPENDING ACCOUNTS (WageWorks)

You may decrease or waive 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 (Daycare) FSA Annual before-tax election _____ (max. \$5,000 per family)

No Change/Keep Same

*** Dependent 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**

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.

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Fax #: 330-315-9220

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

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