Non-Bargaining/Exempt Employees
Spouse Loses Benefits

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

SPOUSE LOSES 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

- A **letter, document or notice** from your spouse employer, healthcare provider, or a HIPAA Certificate must include
  date benefits were or will be terminated, and names of *dependents that were terminated from coverage,*
  or
  A **letter** from spouse's employer verifying retirement date. Or **a letter, document or notice** showing status from Full-Time to Part-Time.

- A copy of your **Marriage Certificate.**

PLEASE NOTE:

Only eligible dependents that are losing coverage during this qualified status change can be added to benefits, verification of those that lost coverage must be included on the letter.

ADDITIONAL VERIFICATION IS REQUIRED IF ADDING DEPENDENT(S):

To add your children up to age 26 yrs, 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 adopted parent. (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.

Non-Bargaining/Exempt Employees
Spouse Loses Benefits

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

EMPLOYEE INFORMATION

SAP NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	HOME PHONE NO.	SEX:
				☐ M ☐ F

NAME	HOME ADDRESS

QUALIFIED STATUS EVENT:

Spouse - Loses Benefits, Retires or Full-Time to Part-Time

RETURN BY DUE DATE:

EFFECTIVE DATE OF CHANGE:

REQUIRED DOCUMENTATION

- A **letter, document or notice** from your spouse employer, healthcare provider, or a HIPAA Certificate must include date benefits were or will be terminated, and names of *dependents that were terminated from coverage, or letter from spouse's employer verifying retirement date.* Or a letter, document or notice showing status from Full-Time to Part-Time.
- A copy of your **Marriage Certificate.**

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

ADDITIONAL DOCUMENTATION REQUIRED IF ADDING CHILDREN:

See enclosed dependent eligibility verification sheet for more information on dependent verification that must be returned with Loss of Coverage Verification.

DENTAL PLAN – (DELTA DENTAL)

I ELECT THE FOLLOWING OPTION	I ELECT THE FOLLOWING DEPENDENT COVERAGE LEVEL
☐ Waive 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
		CH			☐	☐	☐ DISABLED

Non-Bargaining/Exempt Employees
Spouse Loses Benefits

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
☐ Waive 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
		CH			☐	☐	☐ DISABLED

VISION PLAN - (VSP)

I ELECT THE FOLLOWING OPTION	I ELECT THE FOLLOWING DEPENDENT COVERAGE LEVEL
☐ Waive 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
		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
Spouse Loses Benefits

FLEXIBLE BENEFIT ENROLLMENT/CHANGE FORM

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 (Daycare) FSA Annual before-tax election _____ (max. $5,000 per family)

☐ No Change/Keep Same

NOTE: 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.

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 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

Non-Bargaining/Exempt Employees
Spouse Loses Benefits

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
Spouse Loses Benefits

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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