

# Health Care Programs Enrollment Changes

The information on this form is covered under the Privacy Act.

Proc. Ref. 5B, 2.8

Name (Last, First, Middle)			Social Security Number (SSN)			Reason <input type="radio"/> Add <input type="radio"/> Delete		Effective Date	
Participant Data <input type="radio"/> Active <input type="radio"/> Retiree <input type="radio"/> Survivor			Employee ID		Site Location			Site Phone	
Company <input type="radio"/> SRNS <input type="radio"/> SRR			Check Coverage for Selected Dependent(s)			<b>NOTE</b> If you have more than four dependents, print out another OSR 5-200 or write dependents' information on the back of this page.			
Add or Delete (A or D)	Employee or Dependent Name (Last, First, Middle)		Medical	Dental	Vision	SSN	Gender M/F	Date of Birth	Relationship
1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
5			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

### Flexible Spending Account (FSA)

- Traditional Health Care Spending Account annual pledge \_\_\_\_\_ .00  
**NOTE** The total annual pledge cannot exceed the IRS limit.
- Limited Health Care Spending Account annual pledge \_\_\_\_\_ .00  
**NOTE** 1) The total annual pledge cannot exceed the IRS limit.  
2) This account is for those enrolling in **Basic Medical Plan**.  
3) This account can **only** be used to pay for Dental and Vision.
- Dependent Care Spending Account annual pledge \_\_\_\_\_ .00  
**NOTE** 1) The total annual pledge cannot exceed the IRS limit.  
2) This account is for dependent day care expenses **only**.  
3) This account can **NOT** be used for health care expenses.

### Health Savings Account (HSA)

To be eligible to contribute to an HSA:

- You must be enrolled in the Basic Medical Plan
- You cannot be enrolled in Medicare (Part A or B)
- You cannot be claimed as a dependent on someone else's tax return
- You do not have other non-HSA compatible coverage such as a Health Care Traditional FSA or Health Reimbursement Arrangement (HRA)
- You cannot be covered under TRICARE or a former employer's plan in addition to your coverage at SRNS
- You cannot be a veteran who has received medical treatment through the Veterans Health Administration.

When enrolling in the Basic Medical plan, you have the option to open a Health Savings Account (HSA). You can pay for IRS qualified medical expenses and make pre-tax contributions to your HSA up to the IRS limit. Any unused funds will roll over from year to year. The HSA account option is for Employee/Retiree, not dependents.

HSA annual pledge amount \_\_\_\_\_ .00

I authorize the Company to submit data to HSA Bank on my behalf.

**NOTE** You are no longer eligible to contribute to an HSA once you are enrolled in Medicare (Part A or B). You may continue to use your existing balance to pay for future eligible, unreimbursed medical expenses.

### OFFICIAL USE ONLY

May be exempt from public release under the Freedom of Information Act (5 U.S.C. 552), exemption number and category 6 - Personal Privacy. Department of Energy review required before public release.

Name/Org: \_\_\_\_\_ Date: \_\_\_\_\_ Guidance (if applicable): \_\_\_\_\_

**OFFICIAL USE ONLY**  
(When Filled In)

# Health Care Programs Enrollment Changes (Continued)

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**Critical Illness and Accident Insurance**

SRNS and SRR partners with Aflac to offer employees coverage for Critical Illness and Accidental Insurance. Rates for the plans can be found on the Benefits home page by going to; Insite > Services > Human Resources > Benefits > Aflac Plans or external website: [http://www.srs.gov/general/jobs/benefits/index\\_e.htm](http://www.srs.gov/general/jobs/benefits/index_e.htm).

**NOTE** Under the Critical Illness plan, dependent children will automatically receive 50% of the benefit that the employee has elected for coverage. If spousal coverage is elected, the benefit amount will be 50% of the benefit that the employee has elected. The tobacco status is based on the employee's current tobacco status. The spousal premium is determined by the age of the employee not the spouse.

Add the participant/dependent information below.

Company <input type="radio"/> SRNS <input type="radio"/> SRR		Check Coverage for Selected Participant/Dependent(s)										
Add or Waive (A or W)	Participant/Dependent Name (Last, First, Middle)	Critical Illness NonTobacco		Critical Illness Tobacco		Accidental		SSN	Gender M/F	Date of Birth	Relationship	
		10K	20K	10K	20K	High	Low					
1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
5		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Family Status Change**

**NOTE** Select your family status change below and attach supporting documentation. During the year, modifications to benefit elections can only be made if you have a qualifying family status change, and the change you desire to make is consistent with the qualifying event.

Qualifying Family Status Changes Include	For Deletions Only
<input type="checkbox"/> Marriage or divorce <input type="checkbox"/> Birth or adoption of a child and/or a stepchild who will reside in your household <input type="checkbox"/> Death of a spouse/dependent <input type="checkbox"/> Your spouse's/dependent's gain or loss of employment that results in obtaining or losing coverage	Provide a home mailing address if the person losing coverage has an address different from yours.  Name _____ Street _____ City, State, Zip _____

Comments

I certify that the information entered on this form is true and correct to the best of my knowledge.

Participant Name (Print)	Signature	Date
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Return completed and signed form to Service Center, 730-1B.

**For Company Use Only**

Processed By (Print)	Signature	Date
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