QUALIFYING EVENT CHANGE FORM

This form and all supporting documentation of the Qualifying Event **must** be submitted to your local HR Department within **45 days of the event** to allow time to review and verify within the maximum 60 day period.

TEAMMATE INFORMATION

TEAMMATE PRINTED NAME (Last, First)	TEAMMATE ID	DATE SUBMITTED

HOME ADDRESS, CITY, STATE, ZIP CODE	DIVISION NUMBER

QUALIFYING EVENT INFORMATION

ENTER EVENT DATE BELOW

DATE:

It is your responsibility to attach all documentation to prove the type and the date of Qualifying Event.

- ☐ Birth, Placement for Adoption or Legal Adoption
- ☐ Court-Appointed Legal Permanent Guardianship
- ☐ Change in Work Location (Kaiser HMO Only)
- ☐ Part time to Full time
- ☐ Return from Leave (If benefits were terminated by teammate at beginning of leave)

- ☐ Marriage ☐ Divorce
- ☐ Death of Spouse or Dependent

Date of Death _____

Relationship _____

(including Medicare)

- ☐ Spouse/Dependent/TM Gains Coverage
  _____Health _____Dental _____Vision
- ☐ Spouse/Dependent/TM Loses Coverage
  _____Health _____Dental _____Vision

DEPENDENT INFORMATION

DEPENDENT NAME	SOCIAL SECURITY NUMBER	BIRTHDATE	RELATIONSHIP

BENEFIT ELECTION INFORMATION

The changes made to your benefits must be consistent with the type of Qualifying Event. You can not change your current medical plan option (BCBS Core, No Deductible, High Deductible, INO Plan or Kaiser CA & GA HMO) through a QE. See your HR Department for assistance.

MEDICAL

- ☐ Core PPO Plan
- ☐ No Deductible PPO Plan
- ☐ High Deductible PPO Plan
- ☐ INO High Performance Network
- ☐ Kaiser HMO Core (CA)
- ☐ Kaiser HMO Premium (CA)
- ☐ Kaiser HMO Core (GA)
- ☐ Kaiser HMO Premium (GA)
- ☐ No Coverage

- ☐ Teammate Only
- ☐ TM + Spouse
- ☐ TM + Child(ren)
- ☐ TM + Family

METLIFE DENTAL

- ☐ Dental I
- ☐ Dental II
- ☐ No Coverage

- ☐ Teammate Only
- ☐ TM + Spouse
- ☐ TM + Child(ren)
- ☐ TM + Family

VISION

- ☐ VSP I
- ☐ VSP II
- ☐ No Coverage

- ☐ Teammate Only
- ☐ TM + Spouse
- ☐ TM + Child(ren)
- ☐ TM + Family

METLIFE LEGAL PLAN

☐ Teammate & Family ☐ No Coverage

LONG TERM DISABILITY

(Hourly & Driver Teammates Only, requires an Evidence of Insurability approval for initial enrollment through a QE)

☐ Plan 1: 2 Year Duration ☐ Plan 2: 5 Year Duration

☐ Plan 3: To Age 67 ☐ No Coverage

FLEXIBLE SPENDING ACCOUNT (FSA)

☐ Health Care Annual Pledge: $_____
(through end of calendar year)

☐ Limited Purpose Annual Pledge: $_____
(through end of calendar year)

☐ Dependent Care Annual Pledge: $_____
(available with High Deductible plan only, through end of calendar year)

☐ No FSA Election

TEAMMATE OPTIONAL LIFE, ADD, FAMILY AD&D, ACCIDENTAL INJURY, HOSPITAL INDEMNITY, CRITICAL CARE

☐ Opt Life $_____ Election Amount
Refer to EOI guidelines for life amount restrictions

- ☐ AD&D
- ☐ Family AD&D
- ☐ Accidental Injury
- ☐ Hospital Indemnity
- ☐ Critical Care $_____Coverage Amount
- ☐ No Coverage

SPOUSE LIFE

(Selecting more than $25,000 with a Qualifying Event will require Evidence of Insurability)

☐ $10,000 ☐ $15,000 ☐ $25,000
☐ $50,000 ☐ $75,000 ☐ $100,000
☐ No Coverage

DEPENDENT CHILD LIFE

☐ $5,000 ☐ $10,000
☐ $20,000 ☐ No Coverage

TEAMMATE ACKNOWLEDGEMENT

By my signature below, I authorize McLane Company, Inc. to enroll me in the benefits I have requested above and to take pre-tax and post-tax deductions from my taxable earnings to pay for the benefits I have elected. I agree to review my confirmation form to verify that I made my elections accurately, agree to review my paycheck for accuracy, and to report any errors within no more than one (1) pay period.

Teammate's Signature: _____ **Date:** _____