☐ QUALIFIED LIFE EVENT ☐ OPEN ENROLLMENT ☐ NEW HIRE ENROLLMENT

IN Tek & IN Kote HEALTH CARE ELIGIBILITY CHANGE FORM
NON - REPRESENTED SALARIED EMPLOYEES

*(Fill out the appropriate box, sign and date and submit to HR within 31 days of the qualifying life event. *Open Enrollment changes must be submitted by 11/05/19 and will go into effect 01/01/20)*

Last Name:	First Name:	Middle Initial:
Social Security Number: - - __ __ __ __	Payroll No.	

Healthcare

Complete this section if you are enrolling or will continue in the Consumer Driven Healthcare Plan (CDHP). Please select what your current coverage tier should reflect.

○ I elect to enroll or continue in the Consumer Driven Health Plan as: (check appropriate box)	○ Employee Only $74/Month	○ Employee & Spouse $176/Month
	○ Employee &Child(ren) $133/Month	○ Employee & Family $225/Month

Health Savings Account (HSA)

Complete this section if due to a life event you wish to enroll or continue in a Health Savings Account. Completing this section means you certify that you have met the requirements listed on side 2. **Please contact Optum Bank for questions about your personal IRS Contribution Limit. You cannot enroll in a HSA if you have not enrolled in the Consumer Driven Healthcare Plan.**

○ I elect to enroll or continue in the IN Tek & IN Kote USA HSA and certify that I understand and acknowledge the information on side 2

○ **Medicare Enrolled**; I elect to enroll or continue in the IN Tek & IN Kote USA HSA, however, I do not want the employer contribution put into my HSA, I want the cash payment. The cash payment is not applicable to mid-year changes.

○ I do not want the IN Tek & IN Kote USA HSA opened at Optum Bank or am not eligible to contribute to an HSA.

PAYROLL DEDUCTION I hereby instruct IN Tek & IN Kote USA to deduct the following amount into an HSA account in my name with Optum Bank:	○ Payroll Deduction – No Change ○ Payroll Deduction – Change: $____________per pay period

Waiving Healthcare Coverage

Complete this section if you wish to waive your Consumer-Driven Healthcare Plan (CDHP) *If you elect to waive coverage under this plan and receive the annual payment of $1,800.00, payment will be prorated and paid to you on a per pay period basis

○ I elect to waive coverage for myself and eligible dependents. **[You must attach the required proof of other coverage.]**	○ I elect to waive coverage due to being on another IN Tek & IN Kote Non-Represented Salaried Plan (no waiver payment).

Adding/Terminating/Updating Status

Complete this section if due to a life event you wish to add/terminate a dependent or update dependent information. Attach required documents per instructions on side 2. List additional dependent information on plain paper and attach.
Please check the changes that you need to make to your member records: (Check all that apply.)

Add Coverage:	Terminate Coverage:	Update Coverage:
○ Add spouse due to marriage	○ Terminate spouse due to death or divorce	○ Change Dependent status-Handicap
○ Add child-birth / adoption / stepchild	○ Terminate child due to death	○ Disenrollment in Medicare
○ Enroll self due to loss of other coverage	○ Terminate child – no longer eligible	○ Enrollment in Medicare
○ Add spouse and/or child due to them losing other coverage	○ Terminate spouse and/or child due to them gaining other coverage	○ Other:

Check the Box	Name and SSN	Date of Birth	Sex	Membership status
○ Add ○ Terminate ○ Update	Name: SSN:_________-_____-_________	__ __/____/ _________	○ M ○ F	○ Spouse ○ Child ○ Stepchild ○ Handicapped
○ Add ○ Terminate ○ Update	Name: SSN:_________-_____-_________	__ __/____/ _________	○ M ○ F	○ Spouse ○ Child ○ Stepchild ○ Handicapped

Employee Signature ____________________ Date ____________

Retain proof of submission - E-Mail: HUMAN_RESOURCES@mittalco.com
Fax:574-654-1043 **Questions? Contact HR at 574-654-1044**
Payroll will process HSA payroll deduction changes in accordance with the Pay Schedule.

IN Tek & IN Kote HEALTH CARE ELIGIBILITY CHANGE FORM
NON - REPRESENTED SALARIED EMPLOYEES

Note: that changes in eligibility may be done during the plan year only if the employee notifies HR within 31 days of the qualifying life event.

Adding/Terminating/Updating Status or Waiving Healthcare Coverage

To make changes to your coverage or to change the information in your health care benefit file, you must provide the following documentation (check off forms to be attached and send copies only, no originals):

1. Add spouse due to marriage
   - ✦ Marriage Certificate
     - o If spouse was previously married, death certificate or divorce decree for prior marriage
   - ✦ Spouse's Birth Certificate
   - ✦ Spouse's Social Security Card
   - ✦ Proof of spouse's other insurance (if covered under employer's plan)
2. Terminate spouse due to divorce
   - ✦ Divorce decree
3. Terminate spouse or child due to death
   - ✦ Death Certificate
4. Add child - Birth
   - ✦ Birth Certificate
   - ✦ Social Security Card
5. Add child - Adoption
   - ✦ Birth Certificate
   - ✦ Adoption Order
   - ✦ Social Security Card
6. Add stepchild
   - ✦ Birth Certificate
   - ✦ Social Security Card
   - ✦ Proof of other insurance, if any
   - ✦ Additional documentation may be requested if stepchild's custodial parent (employee's spouse) is not added to the plan
7. Change/Update Dependent Status-Handicap
   - ✦ UMR Handicapped Dependent Certification Form
   - ✦ Tax return showing dependent status
8. Terminate/add dependent due to losing/gaining other coverage.
   - ✦ Source of other coverage (is dependent covered as an employee or as a dependent of another person)
   - ✦ Proof of date other coverage begins/terminates
   - ✦ If *adding* dependent, Birth Certificate and Social Security Card
9. Waive Coverage
   - ✦ Proof of other coverage, including coverage start date
10. Disenrollment in Medicare Part A
    - ✦ Disenrollment document provided by the Social Security Office

Benefit enrollment requires a birth certificate and social security card as well as marriage certificate for spouse. This represents the acceptable documentation for benefit enrollment, without exception.

Enrolling in Health Savings Account

I certify and acknowledge the following:

1. I have elected to be an active participant in the IN Tek & IN Kote 2019 Consumer Driven Health Plan and did not waive coverage on the Company's 2019 Open Enrollment Healthcare Eligibility Change Form.
2. I have no other health insurance coverage except what is permitted as 'other coverage' under Code Section 223 (with permitted other coverage including dental, vision, and long-term care insurance coverage).
3. I am not enrolled in Medicare.
4. I am not claimed as a dependent on someone else's tax return.
5. My spouse and I are not participating in a full purpose Healthcare Flexible Spending Account (as distinguished from a limited purpose Healthcare Flexible Spending Account which only covers qualifying dental and vision expenses for you, your spouse, and your eligible dependents).
6. I authorize a Health Savings Account (HSA) to be opened at Optum Bank, adhering to Optum Bank's terms and conditions. I understand that, in compliance with the USA Patriot Act, Optum Bank must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, I may be asked to provide additional information and/or documentation before my account can be established.
7. I agree to notify the Company's HSA Plan Administrator in writing when I am no longer eligible to contribute to an HSA.
8. I understand that I may change my change my payroll deduction contribution amount at any time during the year by completing the Non-represented Salaried Health Savings Account Payroll Deduction Change Form.
9. To the extent necessary to implement coverage and in accordance with rules set forth in the HIPAA Privacy Regulations, I authorize UMR, CVS Caremark, and Optum Bank to request and use any medical, health, employment, and/or insurance information necessary to complete my enrollment, process my claims, provide benefits, and administer benefits.
10. I understand that the HSA is a personal savings account and I am solely responsible for meeting the eligibility requirements for the Internal Revenue Code in order to qualify for the tax benefits for the HSA as well as any penalties that may be assessed if I contribute to an HSA but am not eligible to do so.

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