New Enterprise Stone & Lime Co., Inc.
P.O. Box 77 • New Enterprise, Pennsylvania 16664 • Corporate Office: 814-766-2211 Fax: 814-766-4400

CHANGE IN FAMILY STATUS ELECTION FORM

Employee Name/Address: _____

Employee Social Security Number:_____ Employee Number:_____ Current Date:_____

As a participant in the cafeteria plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in family status. I understand that the change in my benefit election must be necessitated by and consistent with the change in family status and that the change must be acceptable under the Regulations issued by the Department of Treasury and our Master Welfare Benefit Plan. **The request, including appropriate proof of change, must be furnished within 31 days of the status change**. The effective date of change will be made as soon as possible following receipt of the accepted form. By signing below, I authorize New Enterprise Stone & Lime Co., Inc. to deduct any premium cost associated with my authorization for a change in benefits from my paycheck.

I certify that I have incurred the following change in family status:

____ Marriage on _____. Provide a copy of the marriage certificate.

____ Divorce on _____ (a copy of the divorce decree must be sent). Please provide forwarding address of ex-spouse so COBRA paperwork can be mailed: _____

____ Birth or adoption of a child on _____. Provide a copy of the birth certificate.

____ Death of my spouse and/or dependent on _____.

____ Termination of coverage under a plan outside the company on _____. Provide documentation of loss of coverage with effective date.

____ Commencement of coverage under a plan outside the company on _____. Provide proof of other coverage with effective date.

____ Reduction/increase in hours of employment (including a switch between part-time and full-time employment, a strike or a lockout, or the commencement or return from an unpaid leave of absence) by my spouse on _____. Provide proof of coverage with effective date or loss of coverage with loss date.

____ Gain or loss of a dependent's CHIP/Medicaid/Medicare coverage as of _____. Provide proof of gain/loss of coverage with effective date.

____ Open enrollment period for my spouse's employer in which I can now be added/removed from coverages through his/her employer on _____. Provide proof of open enrollment with effective date.

____ Other:_____

_____

_____

Provide documentation showing effective date to support this qualifying event.

_____ _____

Employee's signature date

_____ _____

Accepted - Administrator's signature date

Plan Administrator use only:

Form Received: _____ Effective Date:_____ Adjust PW Accumulators: ____ Adjust Premiums: _____

JDE Benefits Screen:____ JDE Dependent Screen:____ Cigna: ____ Dental:____ VBA: ___ Discovery Benefits (FSA):_____

New Enterprise Stone & Lime Co., Inc.

3912 Brumbaugh Rd. PO Box 77 New Enterprise, PA 16664

CHANGE IN FAMILY STATUS FORM

GENERAL INFORMATION

NAME:	**EMPLOYEE NUMBER:**

A. MEDICAL CHOICE - PRE TAX – Please circle your election.

Options			
Cigna Open Access Plus	Employee	Employee +1	Family
Cigna Choice Fund Open Access Plus Saver H S A	Employee	Employee +1	Family

Indicate below if you are adding or removing a dependent by checking in either the Add or Remove column, then list their name, social security number, date of birth and relationship to you.

Please note: Eligible dependents include your lawful spouse and children. However, if your spouse works for another employer and they have employment-based medical coverage, they are not eligible to be enrolled in the NESL medical plan benefits. Your children/step-children can be covered up to the age of 26.

Add	Remove	Name	SSN	DOB	Relationship

Note: Falsifying dependent information is insurance fraud and is subject to disciplinary action in accordance with company work rules and/or criminal law.

B. MEDICAL OPT OUT

☐ choose to decline to enroll in the medical coverage.

C. FLEXIBLE SPENDING ACCOUNT – PRE TAX

(***CANNOT*** ENROLL IF YOU HAVE THE CIGNA CHOICE FUND OPEN ACCESS PLUS SAVER H.S.A. MEDICAL PLAN)

Plan Year Contribution _____** Maximum plan year contribution $100 - $2,500

Any unused balance remaining in this account will be forfeited.

****Plan Year Contribution should represent your choice from the Qualifying Event Effective date through the end of the plan year (April 30th).**

D. HEALTH SAVINGS ACCOUNT – PRE TAX

(***CANNOT*** ENROLL IF YOU HAVE THE CIGNA OPEN ACCESS PLUS MEDICAL PLAN)

Per Pay Contribution _____

Plan Administrator use only:

Form Received: _____ Effective Date:_____ Adjust PW Accumulators: ____ Adjust Premiums: _____

JDE Benefits Screen:____ JDE Dependent Screen:____ Cigna: ____ Dental:____ VBA: ___ Discovery Benefits (FSA):_____

E. VISION - PRE TAX - Please circle your election.

Vision Benefits of America	Employee	Employee +1	Family

If dependent information is different than dependent information under the medical option, please list dependents below:

Add	Remove	Name	SSN	DOB	Relationship

F. VISION OPT OUT

☐ I choose to decline to enroll in the vision coverage.

G. DENTAL – PRE TAX - Please circle your election.

Delta Dental	Employee	Employee +1	Family

If dependent information is different than dependent information under the medical option, please list dependents below:

Add	Remove	Name	SSN	DOB	Relationship

H. DENTAL OPT OUT

☐ I choose to decline to enroll in the dental coverage.

**** AUTHORIZATION ****

This form represents my benefit choices for the current plan year. I understand that IRS regulations do not permit me to change my elections before the next enrollment unless my family status changes (birth of a child, marriage, divorce, death or change in spouse's employment). I authorize New Enterprise Stone & Lime Co., Inc. to deduct the cost of my elections from my earnings. I further understand that amounts in my Flexible Spending Account that I do not use for eligible expenses during this period will be forfeited.

Signature:_____Date: _____

Forms can be returned to address listed at the top of the form, can be faxed to Shelby at (814) 766-0220 or to Joy at (814) 766-4414, or can be emailed to benefits@nesl.com.

Plan Administrator use only:

Form Received: _____ Effective Date:_____ Adjust PW Accumulators: ____ Adjust Premiums: _____

JDE Benefits Screen:____ JDE Dependent Screen:____ Cigna: ____ Dental:____ VBA: ___ Discovery Benefits (FSA):_____