New Hire Benefit Checklist

As you move through the process of starting your employment with Lehigh Valley Health Network (LVHN), you must also address your benefits. Please use the following checklist to ensure timely enrollment of your LVHN benefits:

☐ **Review the online Benefits New Hire Briefing.** Many of your questions can be answered by watching this presentation and reviewing the attached materials. You may review this presentation as often as you like.

☐ **Questions about your benefits?** The Benefits Team will be at your Connections Orientation to provide a brief benefits overview including a Q&A. You may also ask individual questions with a Benefits Counselor after the Q&A. The Benefits Hotline phone number is 484-884-3199.

☐ **Select your coverage and complete the New Hire Benefits Paperwork (included in this packet).** Remember to review the attachments within the online presentation for detailed benefit plan information.

- Are you enrolling your spouse/same-sex domestic partner to your medical insurance? You must answer the spousal/same-sex domestic partner surcharge question on the medical enrollment form.
- Be sure to check your desired medical and/or dental plans and the appropriate coverage tier.

☐ **Are you enrolling dependents on your medical, dental or vision plans?**

- Please review the following Dependent Eligibility Guidelines for the required supporting documentation (i.e., Marriage License, Birth Certificate, etc.). *The documentation must be submitted within 30 days of your date of hire in order to add each dependent to your insurance.*

☐ **Are you enrolling in the medical (PPO or HSA) plan?**

- All LVHN colleagues are required to complete a Health & Wellness Assessment (HWA) in order to be eligible for medical coverage. **This step is mandatory to be eligible for Choice Plus health benefits.** You will receive a separate e-mail from LVHN a few weeks prior to your date of hire including your Insurance ID number that will be needed to access www.MyPopulytics.com.

☐ **Bring the following items to your Connections Orientation or send to Benefits within 30 days of your date of hire:**

- New Hire Benefit Enrollment forms (Medical/Dental, Vision, FSA) – These forms should be completed and signed (the Vision and FSA enrollment forms only need to be completed if you are electing that coverage).
- Dependent eligibility documentation (see Dependent Eligibility Guidelines) – please do not bring the original document to Orientation, but make a clear copy for each enrolled dependent to submit to HR.

You may also return the attached forms and all applicable documentation to HR

Fax	**Scan and Email**	**Mail**
484-884-0153, Attn: Elizabeth	Elizabeth.fried@lvh.com	P.O. Box 1870 2100 Mack Blvd., 6th Floor Allentown, PA 18105-1870

Interoffice: Human Resources – Benefits
2100 Mack Blvd, 6th Floor

Lehigh Valley Health Network

Affidavit of Dependency for Children

New Hire ☐ Open Enrollment ☐ Life Status Change ☐ Coverage Effective _____

I, _____, submit this Affidavit of
(Employee Name)

Dependency to establish _____ as
(Child's Name)

a dependent child (as defined below) in order to obtain benefits that Lehigh Valley Health Network, Inc. may extend to employees' dependent children through guardianship or marriage.

1. I declare that the dependent child is eligible for benefits because (you must check **one** of these):

   ☐ I have been appointed guardian of the child (attach copy of Court Order).

   ☐ The child is my foster child (attach copy of Court/Agency Order).

2. I agree to notify Lehigh Valley Health Network, Inc. within (30) days of any change in the circumstances attested to in this affidavit.

3. I will provide to the designated Human Resource Representative documents to verify the dependent child's eligibility as per the policy.

4. Annual enrollment may be required.

5. I understand that providing false or misleading information in the Affidavit may result in any or all of the following actions by Lehigh Valley Health Network, Inc.

   a) a requirement that I reimburse Lehigh Valley Health Network, Inc. for all expenses
   b) termination of my employment
   c) other legal action against me

I affirm that the assertions in this affidavit are true to the best of my knowledge.

_____ _____ _____
Employee Signature **Social Security #** **Date**

_____
Employee/Dependent Child's Home Address

_____ _____
Benefits Counselor Signature **Date**

Lehigh Valley Health Network

DEPENDENT ELIGIBILITY

General Guidelines

Lehigh Valley Health Network (LVHN) requires verification of health, dental and vision plan eligibility for dependents of newly hired employees and dependents added to a current employee's coverage as a result of a life event change. This practice will ensure that all covered members of the health, dental and vision plans are eligible under the rules of the plan(s).

- Proof of plan eligibility may be requested by the Plan Sponsor, Lehigh Valley Health Network (LVHN) human resources staff or Spectrum Administrators at any time. When a request is received to add an eligible dependent or, under certain circumstances an enrollee requests a dependent be removed from the plan, documentation will be required. Failure to provide documentation by the date requested will result in ineligibility for plan benefits for the plan year. You will not be able to make any changes until open enrollment the following year unless you experience a qualifying event.

- Refer to plan documentation for definitions of eligible dependents. The term eligible dependent may be used herein to describe a spouse or same-sex domestic partner.

- The term "qualifying event" is used to describe any life event that changes the plan eligibility of an enrollee, spouse, same-sex domestic partner or dependent. Examples of qualifying events include new hire or new eligibility for benefits, birth, marriage, divorce.

- Notice of a change in the qualifying status of an enrollee or dependent must be reported to human resources within 30 days of the date of the event. Required documentation must be provided within 60 days of the date of hire or other qualifying event with the exception of incapacitated dependent children, which requires the documentation to be returned within 31 days. Failure to meet the submission requirements will result in the dependent's removal from coverage retroactive to the date of the life event or denial of eligibility for coverage until the required documentation is submitted. Failure to meet deadlines may result in a lapse of coverage and ineligibility for enrollment until the next open enrollment period.

- For incapacitated dependent children, documentation must be returned within 31 days.

- If claims were incurred and paid for a dependent ultimately deemed ineligible, restitution will be sought retroactive to the date on which termination should have occurred.

- Any enrollee falsifying documents or otherwise enrolling or attempting to enroll an ineligible dependent will be subject to disciplinary action up to and including termination of employment.

- Employees who are covering their dependents on the health, dental and vision plan are required to provide each dependent's Social Security number (SSN). The SSN must be provided in order for claims to be processed.

LEHIGH VALLEY HEALTH NETWORK
DOCUMENTATION REQUIRED TO SUBSTANTIATE DEPENDENT ELIGIBILITY

DEPENDENT	REQUIRED DOCUMENTATION	POSSIBLE RESOURCES TO OBTAIN DOCUMENTATION

Spouse	• Marriage License (this is not the certificate provided from the official conducting the ceremony);
	  ○ Clear copy
	  ○ May be in the form of an online marriage record if available from state or county of record showing the names of spouse and enrollee and the date of marriage; **or,**
		• County courthouse that issued original marriage license. A list of Pennsylvania County Courthouses can be found at www.health.state.pa.us under Health Statistics and Vital Records (www.vitalcheck.com)

	• Valid Military ID for the spouse of the armed services member. Must show both spouse and enrollee's name and SSN; **or,**	• In accordance with military procedures established by the applicable branch of service
	• If a foreign marriage, documentation confirming existence of marriage; **or,**	• Location where marriage was performed
	• Divorce decree (when removing spouse from plan).	• Clerk of county in which divorce was finalized (www.vitalcheck.com)
Same-Sex Domestic Partner	• LVHN Affidavit—Same Sex Domestic Partnership; **and,**	• LVHN Human Resources

	• Three of the following:
	  ○ Joint deed
	  ○ Joint mortgage or residential lease
	  ○ Designation of domestic partner as primary beneficiary for a life insurance policy
	  ○ Durable property and health care powers of attorney
	  ○ Joint ownership of an automobile
	  ○ Joint bank account or credit account; **and,**	

	• If applicable, complete the LVHN Declaration of Tax Status Form.	

DEPENDENT	REQUIRED DOCUMENTATION	POSSIBLE RESOURCES TO OBTAIN DOCUMENTATION
Child(ren) by birth	• Birth Certificate ○ Clear copy	• For Pennsylvania births, birth certificates are available from the PA Department of Health, Division of Vital Records and can be requested by fax, mail or online at www.health.state.pa.us - Fee is $10. *(Many states allow you to order a new birth certificate from their website. Access to other state websites can be linked through www.health.state.pa.us or www.vitalcheck.com or www.usbirthcertificate.net)*

Child(ren) by adoption	• Certificates and court documents showing legal responsibility for the child(ren)
	  ○ Court approved adoption Order
	  ○ Placement letter from court/adoption agency for pending adoptions.
		• County courthouse that issued final adoption order
		
		• County court/adoption agency that issued placement letter

Child(ren) by legal guardianship	• Certificates and court documents showing legal responsibility for the child(ren)
	  ○ Court or agency Order establishing guardianship; **and,**
	  ○ Affidavit of Dependency of Children.
		• County courthouse/agency that issued guardianship order
		
		• LVHN Human Resources

Stepchildren	• The following documents
	  ○ Birth certificate of stepchild listing employee's current spouse as the parent of the step-child(ren); **and,**
	  ○ Marriage license.
		• See possible resources for birth and marriage licenses noted above.

Foster Child(ren)	• Certificates and court documents showing legal responsibility for the child(ren)
	  ○ Court or agency order establishing foster child status; **and,**
	  ○ Affidavit of Dependency of Children; **and,**
	
	• Documentation reflecting the need to provide medical coverage.
		• County courthouse/agency establishing foster child status
		
		• LVHN Human Resources
		
		• County courthouse/agency establishing foster child status

DEPENDENT	REQUIRED DOCUMENTATION	POSSIBLE RESOURCES TO OBTAIN DOCUMENTATION
Same-Sex Domestic Partner's child(ren) by birth	• Birth Certificate ○ Clear copy; **and,** • LVHN-acceptable Proof of Same Sex Domestic partnership.	• For Pennsylvania births, birth certificates are available from the PA Department of Health, Division of Vital Records and can be requested by fax, mail or online at www.health.state.pa.us - Fee is $10. *(Many states allow you to order a new birth certificate from their website. Access to other state websites can be linked through www.health.state.pa.us or www.vitalcheck.com or www.usbirthcertificate.net)* • LVHN Human Resources

Same-Sex Domestic Partner's child(ren) by adoption	• Certificates and court documents showing legal responsibility for the child(ren)
	  ○ Court approved adoption order
	  ○ Placement letter from court/adoption agency for pending adoptions; **and**
	• LVHN-acceptable Proof of Same-Sex Domestic partnership.
		• County courthouse that issued final adoption order
		• County court/adoption agency that issued placement letter
		• LVHN Human Resources

Same-Sex Domestic Partner's child(ren) by legal guardianship	• Certificates and court documents showing legal responsibility for the child(ren)
	  ○ Court or agency order establishing guardianship; **and,**
	  ○ Affidavit of Dependency for Children; **and,**
	• LVHN-acceptable Proof of Same-Sex Domestic partnership.
		• County courthouse/agency that issued guardianship order
		• LVHN Human Resources

Incapacitated Adult Child	• Application for Extended Coverage Due to Incapacitation/Disability (including employee and physician information).	• LVHN Human Resources or Spectrum Administrators

Lehigh Valley Health Network

The benefit elections made on this form are binding for the plans specified and can only be changed due to a qualifying life event during the plan year.

Empl ID # _____

Benefit Action Form

Reason(s) for submitting this form ❑ Enrollment ❑ Status Change _____ DATE ❑ Marriage _____ DATE ❑ Divorce _____ DATE ❑ Birth _____ DATE

❑ Death _____ DATE ❑ Dependent Child No Longer Eligible _____ DATE ❑ Other _____ DATE _____ REASON

Employee Name: _____ Last (Please Print) First M.I. Soc. Sec. No.: _____ Sex: ❑ Male ❑ Female Birthdate: _____

Address: _____ Street City State Zip Code Home Phone: _____

❑ Full Time ❑ Part Time: _____ Hours/week Work Phone: _____ Position: _____ Hire Date: _____ Martial Status: ❑ Single ❑ Married

Is your Spouse or Same-Sex Domestic Partner eligible for medical coverage through their employer, other than LVHN or HNL, or another group health plan, regardless of whether they are enrolled? (not including Medicare, TRICARE or COBRA coverage) ❑ Yes ❑ No (REQUIRED, if enrolling spouse or SSDP in the health plan)

If yes, Employer Name:_____

Do you currently use tobacco products or have you used tobacco products in the last 3 months? ❑ Yes ❑ No (Only Required for Status Changes, if electing the health plan)

LVHN COMPREHENSIVE HEALTH PLAN, INC.	*Employee*	*Employee + Spouse*	*Employee + Child(ren)*	*Employee + Family*
❑ Choice Plus PPO Plan	❑	❑	❑	❑
❑ Choice Plus HSA Plan	❑	❑	❑	❑

If you are electing the HSA plan, do you wish to contribute to your HSA? ❑ Yes ❑ No
$_____ per year (subject to IRS maximum)

Effective Date_____

LVHN DENTAL PLAN	*Employee*	*Employee + Spouse*	*Employee + Child(ren)*	*Employee + Family*
❑ Preventive and Basic	❑	❑	❑	❑
❑ Preventive, Basic, Major & Orthodontic	❑	❑	❑	❑

Effective Date_____

DEPENDENT INFORMATION

Delete/Add	Last Name	First	M.I.	SSN	Relationship	Sex	Birthdate	If dependent residence is different, please specify address below
❑ Delete ❑ Add								Address
❑ Delete ❑ Add								Address
❑ Delete ❑ Add								Address
❑ Delete ❑ Add								Address
❑ Delete ❑ Add								Address
❑ Delete ❑ Add								Address

Changes to coverage as a result of a life status change must be submitted to Human Resources within 31 days of the qualifying event. Depending on your life event, you may only be permitted to change your deductions, not enroll, as a result of your life status change according to the plan document and IRS regulations.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFICIARY DESIGNATION

Effective Date_____

MY BENEFICIARY:_____

(Please Print) Last Name First Name M.I. S.S. # % Relationship

Last Name First Name M.I. S.S. # % Relationship

Last Name First Name M.I. S.S. # % Relationship

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survives the Insured, unless otherwise provided herein. If no designated beneficiary survives the insured, settlement will be made to the estate of the Insured unless otherwise provided in the Group Policy.

STATEMENT OF AUTHORIZATION

I understand this application is subject to approval by the Plans and any coverage will be subject to the terms of the Plan Documents. I authorize any hospital, physician, dentist or health care provider to furnish Lehigh Valley Health Network, Inc., or its assignee, with medical or dental information about the enrollees as may be required by the Plans. I authorize appropriate payroll deduction(s), if applicable:

Any person who knowingly defrauds any insurance company by filing an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent act. This is a crime and could subject such person to criminal and civil penalties.

Signature: _____ Date: _____

HUMAN RESOURCES VERIFICATION

(To be completed by Human Resources) Benefits Counselor: _____

RETURN COMPLETED FORM TO HUMAN RESOURCES

VISION BENEFITS OF AMERICA VBA# 1741 SUBGROUP#_____
ENROLLMENT FORM

COVERAGE EFFECTIVE DATE _____/_____/_____

INSTRUCTIONS FOR EMPLOYEE:
1. COMPLETE SECTION BELOW AND SIGN.
2. RETURN COMPLETED FORM TO YOUR BENEFITS OFFICE.

EMPLOYEE SOCIAL SECURITY NUMBER _____

EMPLOYEE NAME _____ BIRTHDATE ____|_____|_____

ADDRESS _____

CITY _____ STATE_____ZIP CODE _____-_____

PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

	FIRST NAME	**MIDDLE INITIAL**	**LAST NAME**	**BIRTHDATE**
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				

STUDENT INFORMATION (COMPLETE FOR DEPENDENTS WHO ARE ENROLLED **AS FULL-TIME COLLEGE STUDENTS**.)

STUDENTS NAME	NAME OF SCHOOL OR UNIVERSITY	

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME		

EMPLOYEE SIGNATURE _____ DATE _____/_____/_____

Lehigh Valley Health Network

The benefit elections made on this form are binding for the plans specified and can only be changed due to a qualifying life event during the plan year.

Empl ID # _____

Flexible Spending Form

Reason(s) for submitting this form: ❑ Enrollment ❑ Marriage _____ DATE ❑ Divorce _____ DATE ❑ Birth _____ DATE

❑ Death _____ DATE ❑ Dependent Child No Longer Eligible _____ DATE ❑ Status Change _____ DATE

❑ Other _____ DATE _____ REASON

Employee Name: _____ Soc. Sec. No.: _____
Last (Please Print) First M.I.

Sex: ❑ Male ❑ Female Birthdate: _____ Home Phone: _____

Address: _____
Street City State Zip Code

❑ Full Time ❑ Part Time: _____ Hours/week

Work Phone: _____ Dept: _____ Hire Date: _____ Martial Status: ❑ Single ❑ Married

All health and child/elder FSA claims need to be submitted for reimbursement by March 31st of the following calendar year, any unused money remaining in your account(s) will be forfeited. Colleagues enrolling in an FSA can submit eligible expenses incurred beginning with their first date of coverage only.

HEALTH CARE FLEXIBLE SPENDING (If you are electing the Choice Plus HSA plan, you cannot elect a Health Care FSA.)

❑ Health Care FSA $ _____ per year Effective Date _____

You will be issued a debit card for the Health Care FSA.

CHANGES (Do not complete if you are enrolling for the first time)

Date of life status change: _____ Type of life status change _____

❑ Cancel ❑ Change

Current Amount $ _____ per year New Amount $ _____ to be deducted per year

HEALTH CARE FSA: The minimum annual participation is $100; maximum is $2,500. Please note that any premiums you are paying for health, dental, and/or vision coverage will be deducted on a pre-tax basis and should NOT be included in the amount you elect to contribute to your health FSA. You may only be reimbursed for qualifying expenses that you incur during the calendar year.

CHILD/ELDER CARE FLEXIBLE SPENDING

❑ Child/Elder Care FSA $ _____ per year Effective Date _____

CHANGES (Do not complete if you are enrolling for the first time)

Date of life status change: _____ Type of life status change _____

❑ Cancel ❑ Change

Current Amount $ _____ per year New Amount $ _____ to be deducted per year

CHILD/ELDER CARE FSA: The maximum annual participation is $5,000 per family. You may only be reimbursed for qualifying expenses that you incur during the calendar year.

STATEMENT OF AUTHORIZATION I understand this application is subject to approval by the Plans and any coverage will be subject to the terms of the Plan Documents. I authorize any hospital, physician, dentist or health care provider to furnish Lehigh Valley Health Network, Inc., or its assignee, with medical or dental information about the enrollees as may be required by the Plans. I authorize appropriate payroll deduction(s), if applicable:

Any person who knowingly defrauds any insurance company by filing an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent act. This is a crime and could subject such person to criminal and civil penalties.

Signature: _____ Date: _____

HUMAN RESOURCES VERIFICATION (To be completed by Human Resources) Division #: Benefits Counselor: _____

RETURN COMPLETED FORM TO HUMAN RESOURCES

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

ABOUT YOUR 403(b) RETIREMENT PLAN

As an eligible employee of Lehigh Valley Health Network, you are permitted to participate in a 403(b) tax deferred retirement program.

What is a 403(b) plan?

A 403(b) plan is a tax-deferred retirement plan available to employees of educational institutions and certain non-profit organizations. In this plan, you can make pre-tax contributions for retirement savings. Distributions generally are only available when you reach age 59 ½ or experience a severance of employment. However, distributions can also be available in the event of financial hardship, death, or disability. Short-term needs also can sometimes be met by non-taxable loans.

Why contribute to a 403(b)?

Participating in your plan can provide a number of benefits, including:

- **LOWER TAXES TODAY.** Your 403(b) contributions are made on a pre-tax basis which can greatly reduce your current income tax bill. For example, if your federal marginal income tax rate is 25%, and if you contribute $100 a month to a 403(b) plan, you've reduced your federal income taxes by roughly $25 (assuming a 25% tax bracket). In effect, your $100 contribution costs you only $75. The tax savings can grow with the size of your 403(b) contribution.

- **TAX-DEFERRED GROWTH.** Your account in the 403(b) plan are tax-deferred. This means that your account can grow tax-free until time of withdrawal.

- **ENHANCED RETIREMENT.** Other sources of retirement income, including state pension plans and, if applicable, Social Security, often do not adequately replace a person's salary upon retirement. A 403(b) plan can provide a healthy supplement to an employee's retirement income.

How do I get more information?

To obtain more information, including information about how to participate, and about the savings products made available under the plan, contact the following VALIC advisors:

Michael Ryan –	(610) 644-9497	Richard Silva, Sr. –	(610) 349-3616
Kevin Gertz –	(610) 392-9912	Tim Schroyer –	(717) 379-1920
Jeffrey Hofmann –	(717) 773-6176		

◆ ❑ ◆

Not intended as tax or legal advice. Neither your employer nor the investment providers offering savings products under the plan can provide you with tax or legal advice.