

10-DAY FREE LOOK REQUEST

Complete the necessary sections pertaining to one or more of the changes outlined below within the 10-day free look period. Requests will need to be submitted by the 10th day of the effective month.

Research Associate: _____

ID Number: _____

*** The below section contains request to increase deductible on current plan category. Deductible decrease changes will not be permitted through this form.*

VL	\$500	\$750	\$1,000	\$1,500
EPO	\$500	\$750	\$1,000	\$1,500
HSA	\$3,500	\$5,000	\$8,300	
MM	\$1,000	\$2,500	\$3,500	
MM+	\$4,900	\$7,250		

Level of Coverage (Please Check One)	EE	ESP	ECH	FAM
---	----	-----	-----	-----

*** Network change requests due to recruiter error may be selected below. Recruiter must sign off on request.*

Requested Network Change: CIGNA PHCS

Recruiter Signature: _____ **Date:** _____

If no plan or network changes. Please proceed to page 2

Dependent Add/Removal

*** Disclosure: Under ACA Guidelines, dependents age 26 and over must obtain their own medical coverage. To add a dependent child, you must be a legal guardian.*

ADD:

Name (First and Last)	DOB	Gender	Social	Relationship

I hereby attest that I have reviewed the completed health questionnaire. The responses indicate no contradictions or health-related restrictions for the requested party being added. Therefore, the individual is deemed eligible to participate, contingent upon the accuracy and completeness of the information provided. _____ (Initial)

REMOVE:

Name (First and Last)	DOB	Gender	Social	Relationship

I would like to remove the above-mentioned participant(s) within my 10-day free look period. _____ (Initial)

****I acknowledge that changes made through submitting this form may change the amount paid for monthly employee coverage contributions and authorize the requested changes to be made to my contributions. _____ (Initial)*

Research Associate Signature: _____ **Date:** _____