



Family Status Changes

Under the Plan rules, you may make certain mid-year changes in your benefit elections if you request the change within 31 days of a change in your family status. Below is a list of qualified family status changes and the documentation required for a change to be made. For a more detailed description of family status changes and allowable benefit changes, see your *Benefits Handbook* (available online or from your Human Resources Dept. or by calling the Dresser Benefits Center.)

FAMILY EVENTS

1. Marriage; adding spouse
2. Birth or Adoption of child; or adding child
3. Divorce, legal separation
4. Death of spouse or child
5. Child is no longer eligible or becomes eligible
6. Spouse becomes eligible for other employer plan due to new job or open enrollment
7. Dependent loses eligibility in other employer plan due to change in employment status or loss of COBRA
8. Dependent becomes eligible for Medicaid or CHIP
9. Court Order requires you to provide coverage for a dependent
10. Change in child care provider or significant change in costs of care

REQUIRED DOCUMENTATION (copies only)

- Copy of recent federal tax return or marriage certificate/ Common Law Spouse Affidavit* - plus proof of residence for spouse if not just married.
- Copy of birth certificate**, adoption papers or court order granting custody plus proof of school enrollment if over age 19.
- Copy of the divorce decree or separation papers (just pages with signatures and court seal or stamp.
- Employee affidavit ***
- Employee affidavit ***; proof of student status if applicable
May require a Dependent Eligibility Questionnaire *
- Benefit enrollment or eligibility notice from other employer
- HIPAA Certificate of Creditable Coverage; COBRA notice or letter from employer. If adding coverage for depts, see # 1 and 2 above.
- Copy of coverage notice from the State or local authority showing effective date
- Copy of court order, Qualified Medical Child Support Order or national medical support order
- Employee affidavit *** + copies of receipts before and after change

* Request this form from the Dresser Benefit Center: Phone: 1-866-325-8214 or online at www.bcbstx.com/dresser (use the Dresser Benefits Administration link and go to "Forms").

** If this is not available yet, do not delay sending in the Family Status Change Form. You may send in the birth certificate when it is available.

***An Employee Affidavit is a written statement explaining the reason you are requesting to make a change to your current benefit elections. The statement is not valid unless it includes a signature and date. In the case of a dependent death, the signed and dated Family Status Change Form will be enough.

Instructions for Making Mid –Year Benefit Changes

1. Review the list of family status changes here and in your Benefits Handbook to determine if your life event is one that qualifies for a change in benefit elections.
2. Note the documentation required for certain events. Make photocopies of any required documentation.
3. Gather information on the dependents affected by the change: Full Name, Birth date, Social Security Number (if the change is the birth of a child, do not wait until you have the SSN to complete the form. Call in the SSN later.
4. Complete the Dresser Family Status Change Form. If other forms are required or you have any questions, call the Dresser Benefit Center at 1-866-325-8214.
5. **Mail or fax the Change Form and required documentation to the Dresser Benefit Center no later than 31 days after the family status change event.** Except for the birth of a child, coverage may not take effect until the Change Form is received. If there is a delay in obtaining the documentation, send the Family Status Change Form immediately and include a note with the reason for the lack of documentation and when you anticipate sending it. Coverage will be pending until receipt of any required documentation.

SECTION D. Your New Benefit Elections

Your new elections must coincide with the type of event—See Employee Benefit Handbook for allowable changes.

PLAN	CHECK THE COVERAGE YOU WISH TO CHANGE
Medical Plan Name: _____	Coverage for: <input type="checkbox"/> No coverage <input type="checkbox"/> You Only <input type="checkbox"/> You + Children <input type="checkbox"/> You + Spouse <input type="checkbox"/> Family
Dental Plan Name: _____	Coverage for: <input type="checkbox"/> No coverage <input type="checkbox"/> You Only <input type="checkbox"/> You + Children <input type="checkbox"/> You + Spouse <input type="checkbox"/> Family
Vision (if available)	Coverage for: <input type="checkbox"/> No coverage <input type="checkbox"/> You Only <input type="checkbox"/> You + Children <input type="checkbox"/> You + Spouse <input type="checkbox"/> Family
Optional Life – Employee (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$ _____ (write in the amount elected)
Optional Spouse Life (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> _____ (write in the amount elected)
Optional Child Life (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> _____ (write in the amount elected)
Optional Employee AD&D (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> _____ (write in the amount elected)
Optional Spouse AD&D (If available) (\$.028 per \$1,000 of coverage)	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$50,000 <input type="checkbox"/> 50% of Employee Amount <input type="checkbox"/> 100% of Employee Amount
Optional Child AD&D (If available) (\$.021 per \$1,000 of coverage)	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000
Health Care Flexible Spending Account (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$ _____ /month (\$10 min.; \$333 max)
Dependent Care Flexible Spending Account (if available)	<input type="checkbox"/> No Coverage <input type="checkbox"/> \$ _____ /month (\$10 min.; \$208 max if married, separate return; \$416 max if single or married, joint return)

SECTION E. EMPLOYEE AUTHORIZATION

I hereby elect the changes noted on the form above and attest that the change is made on account of and is consistent with my family status change. I have read the enrollment material provided to me and understand that eligibility and benefit coverage is governed by the official plan documents and insurance contracts, which may be modified from time to time.

I understand that eligibility for and participation in Dresser, Inc. benefits is based on the information that I have provided about myself and my eligible dependents and that any misstatement or inaccuracy on my part may affect my eligibility for and participation in the benefit plans. I certify the information I provided is true and accurate.

Employee Signature

Date

No request for changes can be accepted without your signature and date.