

☐ QUALIFIED LIFE EVENT

☐ OPEN ENROLLMENT

☐ NEW HIRE ENROLLMENT  **CLIFFS**

**CLEVELAND-CLIFFS STEEL LLC — HEALTH CARE ELIGIBILITY CHANGE FORM
REPRESENTED HOURLY or O&T EMPLOYEES**

Last Name	First Name	M.I.	Payroll No.	Social Security Number
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Please check the changes that you need to make to your member records: (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Add spouse due to marriage | <input type="checkbox"/> Terminate dependent due to gaining other coverage |
| <input type="checkbox"/> Terminate spouse due to divorce | <input type="checkbox"/> Enroll due to losing other coverage |
| <input type="checkbox"/> Terminate spouse due to death | <input type="checkbox"/> Add dependent due to losing other coverage |
| <input type="checkbox"/> Add child-birth / adoption / stepchild | <input type="checkbox"/> Waive / Terminate coverage* |
| <input type="checkbox"/> Terminate child due to death | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Terminate child-no longer eligible | |
| <input type="checkbox"/> Change/Update Dependent status-handicap | |

*If you elect to waive coverage under this plan and receive the annual payment of \$3,600.00, payment will be prorated and paid to you on a pay period basis.

ONLY COMPLETE THE SECTIONS THAT APPLY TO CHANGES IN YOUR ENROLLMENT STATUS:

Street Address		City	State	Zip Code	Phone
	Employee ○Add ○Waive ○Change	Spouse ○Add ○Drop ○Change	Dependent ○Add ○Drop ○Change	Dependent ○Add ○Drop ○Change	
Social Security Number					
Previous Last Name					
New Last Name					
First Name Middle Initial					
Sex (M/F)	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Membership Status	○ Single ○ Married	<input type="checkbox"/> Spouse	○ Child ○ Stepchild ○ Other _____ ○ Handicapped > 26	○ Child ○ Stepchild ○ Other _____ ○ Handicapped > 26	
Documentation Required	See other side.	See other side.	See other side.	See other side.	
Birth Date	Month Day Year	Month Day Year	Month Day Year	Month Day Year	

List additional dependent information on plain paper and attach. ☐ Check here if you are attaching a list of additional dependents.

• Attach required documentation per instructions on page 2 of this form. Retain proof of submission – For Open Enrollment must be sent by 11/5/2021 11:59 pm CST (1) Email (2) Faxed Confirmation Delivery

- ☐ I elect to enroll in the PPO Medical/Rx, Vision & Dental Coverage as: ☐ Employee Only ☐ Employee & Spouse
☐ Employee & Family ☐ Employee & Child(ren)
- ☐ I elect to enroll in the CDHP Medical/Rx, Vision & Dental Coverage as: ☐ Employee Only ☐ Employee & Spouse
☐ Employee & Family ☐ Employee & Child(ren)
- ☐ I elect to **waive all health care coverage** (Medical/RX, Vision and Dental) for myself and my eligible dependents.
Note: To elect this option you must attach the required proof of other coverage.
- ☐ I elect to **waive Medical/RX only coverage** for myself and my eligible dependents.
Note: To elect this option you must attach the required proof of other coverage.

Signature	Date	Work Phone	Cleveland-Cliffs Business Unit/Location
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After signing, make a copy for your records and return form by:

Email: cliffs@umr.com
Fax: 855-307-8354
Questions call: 800-268-3489

Internal Use Only:

Status: ☐ Approved ☐ Incomplete ☐ Late Termination/Change

Date _____ Initials _____

Notes: _____

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
 - 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
 - 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* spouse/dependent, Marriage Certificate, Birth Certificate and Social Security Card
9. Waive Coverage
 - Proof of other coverage, including coverage start date
10. Reinstatement from a Waiver
 - Proof of other insurance termination letter, Marriage Certificate, Birth Certificate and Social Security Card

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.

IMPORTANT: Retain proof of submission – For Open Enrollment your request must be sent prior to 11/05/2021 11:59 pm CST
Acceptable Proof of submission: (1) Email or (2) Faxed Confirmation Delivery