FORM INSTRUCTIONS AND INFORMATION

- Complete both sides of this form in full to request a change(s) to your current benefit election(s), due to a qualified family status change. Qualified family status changes include: marriage, formation or dissolution of a domestic partnership, divorce, legal separation, reduction or increase in the hours of your employment or your spouse's employment, moving your place of residence, birth or legal adoption, death of a dependent/domestic partner and a change in your spouse's employment status that affects your spouse's benefits eligibility under another employer's plan. Please contact the Canon Medical Systems Benefits Department at benefits@us.medical.canon if you are unsure of the type of changes you are eligible to make.
- Supporting documentation (e.g., Birth announcement, marriage certificate, dissolution of marriage, divorce decree, COBRA notification, proof of spouse's loss or gain of coverage elsewhere) and appropriate carrier change form, as applicable, must be submitted with this form for approval and processing.
- **This form and supporting documentation must be received by the Benefits Department no later than 31 days from the date of your family status change.**
- Approved changes received within the above timeframe will take effect on the date of notification. In certain situations, this could be the same day of your qualifying event.
- If you are adding coverage mid-month, you will be charged the full month's premium. Vendor premiums are not pro-rated.

SECTION I - GENERAL EMPLOYEE INFORMATION

Print Name: Last	First	M.I.	Date of Birth	Social Security Number

Street Address	City	State	Zip

Daytime Phone	Work Location	Date of Hire

SECTION II - FAMILY STATUS CHANGE EVENT

- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce/Legal Separation
- ☐ Formation of domestic partnership that meets Company criteria
- ☐ Loss of full-time student status
- ☐ Death of dependent/domestic partner
- ☐ Commencement of spouse's employment
- ☐ Termination of spouse's employment
- ☐ Employment status change of dependent/domestic partner
- ☐ Dissolution of domestic partnership
- ☐ Other _____

Date of Above Event

_____

Indicate Proof Being Submitted To Support Above Event

- ☐ Marriage license
- ☐ Birth certificate or announcement
- ☐ Divorce decree/dissolution of marriage/legal separation document
- ☐ Company letter indicating qualifying event
- ☐ COBRA enrollment
- ☐ Domestic Partners Enrollment Guide
- ☐ Declaration of termination of domestic partnership
- ☐ Other _____

SECTION III - BENEFIT CHANGES

MEDICAL CHANGE ELECTION - The Aetna network of providers can be located online at http://www.aetna.com

- ☐ EPO
- ☐ CDHP Basic
- ☐ CDHP Select
- ☐ CDHP Premier
- ☐ First Time Medical Election
- ☐ Addition to Medical Required
- ☐ Deletion to Medical Coverage**/***

DENTAL CHANGE ELECTION - The Delta Dental network of providers can be located online at https://www1.deltadentalins.com/.

- ☐ Delta Dental PPO Plan
- ☐ First Time Dental Election
- ☐ Addition to Dental Required
- ☐ Deletion to Dental Coverage***

VISION CHANGE ELECTION

- ☐ VSP Vision Plan
- ☐ First Time Vision Election
- ☐ Addition to Vision Required
- ☐ Deletion to Vision Coverage***

OTHER INSURANCE COVERAGE FOR SPOUSE

Spouse's Employer: _____ Spouse's Insurance Carrier: _____

Is spouse eligible for coverage under this employer: ☐ Yes ☐ No

Is spouse covered under this carrier: ☐ Yes ☐ No

**** EMPLOYEE DELETION OF MEDICAL COVERAGE:**

PROOF OF OTHER COVERAGE CERTIFICATION

My initials certify that myself and my eligible dependents (as applicable) are covered under another qualifying medical benefit plan. I am able to provide proof of such coverage if required. _____**(please initial)**

*** **DELETION OF DEPENDENT COVERAGE: Deleted dependent's address must be provided to the Benefits Department for COBRA mailing purposes.**

Address:_____

FLEXIBLE SPENDING ACCOUNTS – Additional FSA Change Form Must Accompany This Form.
Limited Health Care Account/Dependent Care Account

Must complete FSA Change Form

HEALTH SAVINGS ACCOUNT (HSA) – Additional HSA Change Form Must Accompany This Form.
Health Savings Account (HSA) / Health Savings Account Catch-up

Must complete HSA Change Form

OPTIONAL SHORT-TERM DISABILITY ELECTION

☐ I elect the Company STD Plan

☐ I waive this coverage

If you are located in California and you waive the Company STD plan, you will automatically be enrolled in California's mandated State Disability Income (SDI) program.

ACCIDENT INSURANCE ELECTION

If you are enrolled in a Company medical plan, you will be automatically enrolled in Accident Insurance at the 'employee only' tier level – this is a company paid benefit. You may purchase additional coverage for your eligible dependents.

☐ Enroll in Employee Only coverage
☐ Enroll in Employee + Spouse/DP coverage
☐ Enroll in Employee + Child(ren) coverage
☐ Enroll in Employee + Family coverage
☐ Waive Accident Insurance

HOSPITAL CONFINEMENT INDEMNITY INSURANCE ELECTION

If you are enrolled in a Company medical plan, you will be automatically enrolled in Hospital Confinement Indemnity Insurance at the 'employee only' tier level – this is a company paid benefit. You may purchase additional coverage for your eligible dependents.

☐ Enroll in Employee Only coverage
☐ Enroll in Employee + Spouse/DP coverage
☐ Enroll in Employee + Child(ren) coverage
☐ Enroll in Employee + Family coverage
☐ Waive Hospital Confinement Indemnity Insurance

LEGAL INSURANCE

☐ Enroll in Employee Only coverage
☐ Enroll in Employee + Dependent(s) coverage
☐ Waive Legal Insurance

IDENTITY PROTECTION INSURANCE

☐ Enroll in Employee Only coverage
☐ Enroll in Employee + Dependent(s) coverage
☐ Waive Identity Protection Insurance

SECTION IV – VOLUNTARY CRITICAL ILLNESS INSURANCE CHANGES

EMPLOYEE CRITICAL ILLNESS ELECTION

Have you smoked or used any form of tobacco in the past 12 months? ☐ Yes ☐ No

☐ Waive voluntary critical illness coverage ☐ $5,000 ☐ $10,000 ☐ $20,000 ☐ $30,000

SPOUSE/DP CRITICAL ILLNESS ELECTION

Has your spouse/DP smoked or used any form of tobacco in the past 12 months? ☐ Yes ☐ No

☐ Waive voluntary critical illness coverage ☐ $5,000 ☐ $10,000 ☐ $20,000 ☐ $30,000

SECTION V – SUPPLEMENTAL LIFE INSURANCE CHANGES

SUPPLEMENTAL LIFE ELECTION (FIELD SALES PERSONNEL)

(defined as Senior Account Executive, Account Executive, Senior Key Account Executive, Key Account Executive, Senior Zone Business Manager, Zone Business Manager, Zone Sales Manager, Senior Zone Financial Sales Manager, Zone Financial Sales Manager, Senior SBG Manager, SBG Manager, Director National Product Sales, Clinical Sales Support Specialist Senior, Clinical Sales Support Specialist, Manager Region Sales, Senior Manager Region Sales, UL Manager Region Sales, UL Senior Manager Region Sales, VP Ultrasound Sales, Director SBG, VP SBG, Senior Director of Alternate Channel, Senior Alternate Channel Manager, Director Integrated Delivery Networks, Senior Zone Business Manager CT Oncology, Director GOV SBG, Manager SBG GPO, VP Strategic Business and VP IDN SBG).

☐ Waive Supplemental Life ☐ $100,000 ☐ $200,000 ☐ $300,000 ☐ $400,000 ☐ $500,000 ☐ $600,000

If you are electing to increase your life insurance by more than 1x your current election, you will need to complete the Voya Evidence of Insurability (EOI) form.

SUPPLEMENTAL LIFE ELECTION (ALL OTHER EMPLOYEES)

☐ Waive Supplemental Life ☐ 1x Annual Salary ☐ 2x Annual Salary ☐ 3x Annual Salary ☐ 4x Annual Salary ☐ 5x Annual Salary

If you are electing to increase your life insurance by more than 1x your current election, you will need to complete the Voya Evidence of Insurability (EOI) form.

SPOUSE DEPENDENT LIFE INSURANCE ELECTION (Employee must be enrolled under the Supplemental Life Insurance plan to elect this coverage)

☐ Waive Dependent Life ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

Coverage: Spouse (child coverage is included at $5,000 per child)

If you are electing to increase your dependent life insurance by more than 1x your current election, your spouse will need to complete the Voya Evidence of Insurability (EOI) form. Any election over $50,000 also requires your spouse to complete the Voya Evidence of Insurability (EOI) form.

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) ELECTION

☐ Enroll in Employee Only coverage ☐ $ 25,000 ☐ $ 50,000 ☐ $ 75,000 ☐ $ 100,000 ☐ $ 125,000

☐ Enroll in Employee + Family coverage ☐ $150,000 ☐ $ 175,000 ☐ $ 200,000 ☐ $ 225,000 ☐ $ 250,000

☐ Waive Optional AD&D

SECTION VI - DEPENDENT INFORMATION

☐ **Add the Following Dependents** ☐ **Delete the Following Dependents**

Dependent Name	Date of Birth	Sex	Social Security Number	Relation	Complete for Dependent Children age 19 and over: Full Time Student Yes/No	Complete for Dependent Children age 19 and over: Name of Accredited School
Self						
Spouse						
Child(ren)						

SECTION VII - AGREEMENT

I understand that by signing this form I have made a binding agreement of election for benefits, effective from the date of this change through December 31, 2026. I also hereby authorize the deductions to be withheld from my earnings (which will be taken on a pre-tax basis, with the exception of short-term disability insurance, supplemental life and dependent life insurance) to serve as payment for any required employee contributions. Furthermore, I may not change my benefit election(s) unless a change is necessitated by another qualified family status change.

Employee Signature _____ Date _____