Infineum USA Inc.

BENEFITS CHANGE FORM

PRIVATE and CONFIDENTIAL

1. COLLEAGUE INFORMATION (Please Print)

NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY NO. / /
ADDRESS (STREET, PO BOX, APARTMENT NO.)		HOME PHONE NUMBER / CELL PHONE NUMBER
CITY, STATE, ZIP CODE	COUNTY	HOME EMAIL ADDRESS

ABOVE INCLUDES: ❑ Address/Phone Change ❑ Name Change / Former Name:

2. MARITAL STATUS CHANGE

❑ MARRIED ❑ DIVORCED ❑ WIDOWED	SPOUSE'S NAME (LAST, FIRST, MIDDLE)	
EFFECTIVE DATE OF MARITAL STATUS CHANGE:	SPOUSE'S SSN# / /	SPOUSE'S DATE OF BIRTH

3A. MEDICAL COVERAGE CHANGE

CURRENT PLAN (CHECK ONE)

❑ Infineum Medical Plan 1 ❑ Infineum Medical Plan 2 ❑ Infineum Medicare Supplement Plan

❑ Not Currently Enrolled

CURRENT CLASS OF COVERAGE (CHECK ONE)

❑ SINGLE ❑ INDIVIDUAL +ADULT ❑ INDIVIDUAL + CHILD(REN) ❑ FAMILY ❑ NO COVERAGE

3B. NEW CLASS OF COVERAGE

ACTION (CHECK 0NE)

❑ ADD COVERAGE ❑ ADD ELIGIBLE FAMILY MEMBER(s)

❑ DELETE COVERAGE ❑ DELETE ELIGIBLE FAMILY MEMBER(s)

QUALIFYING EVENT (SEE PG. 9 IN THE 'OVERVIEW OF YOUR Infineum BENEFITS')

OPEN ENROLLMENT – changes effective January 1, 2024

	NAME (LAST, FIRST, MIDDLE)	GENDER	DATE OF BIRTH	SOC. SEC. NO.
YOU		❑ MALE ❑ FEMALE		/ /
SPOUSE		❑ MALE ❑ FEMALE		/ /
DOMESTIC PARTNER		❑ MALE ❑ FEMALE		/ /
CHILD		❑ MALE ❑ FEMALE		/ /
CHILD		❑ MALE ❑ FEMALE		/ /
CHILD		❑ MALE ❑ FEMALE		/ /
CHILD		❑ MALE ❑ FEMALE		/ /

NEW PLAN (CHECK ONE)

❑ Infineum Medical Plan 1 ❑ NO COVERAGE

NEW CLASS OF COVERAGE (CHECK ONE)

❑ SINGLE ❑ INDIVIDUAL +ADULT ❑ INDIVIDUAL + CHILD(REN) ❑ FAMILY ❑ NO COVERAGE

(OVER)

4A. DENTAL COVERAGE CHANGE

CURRENT CLASS OF COVERAGE (CHECK ONE)

❑ SINGLE ❑ INDIVIDUAL +ADULT ❑ INDIVIDUAL + CHILD(REN) ❑ FAMILY ❑ NO COVERAGE

4B. NEW CLASS OF COVERAGE

ACTION (CHECK ONE)

❑ ADD COVERAGE ❑ ADD ELIGIBLE FAMILY MEMBER(s)

❑ DELETE COVERAGE ❑ DELETE ELIGIBLE FAMILY MEMBER(s)

QUALIFYING EVENT (SEE PG. 9 IN THE 'OVERVIEW OF YOUR Infineum BENEFITS')

OPEN ENROLLMENT – changes effective January 1, 2024

	NAME (LAST, FIRST, MIDDLE)	GENDER	DATE OF BIRTH	SOC. SEC. NO.
YOU		❑MALE ❑FEMALE		/ /
SPOUSE		❑MALE ❑FEMALE		/ /
DOMESTIC PARTNER		❑MALE ❑FEMALE		/ /
CHILD		❑MALE ❑FEMALE		/ /
CHILD		❑MALE ❑FEMALE		/ /
CHILD		❑MALE ❑FEMALE		/ /
CHILD		❑MALE ❑FEMALE		/ /

NEW CLASS OF COVERAGE (CHECK ONE)

❑ SINGLE ❑ INDIVIDUAL +ADULT ❑ INDIVIDUAL + CHILD(REN) ❑ FAMILY ❑ NO COVERAGE

5. EFFECTIVE DATE OF CHANGE(S)

MJONTH	DAY	YEAR
January	1	2024

I understand that I cannot change my elections, add or delete coverage during the plan year unless I have a qualifying change in status (for more information, see the Overview of Your Infineum Benefits section, Pg. 9, of your Colleague Employment Handbook). I understand that I may change my elections during a plan's open enrollment period or annual election period. If I decline medical/dental coverage, I understand and agree that Infineum is not liable for any expenses that would otherwise be covered by the medical and/or dental plan.

6. SIGNATURE AND DATE

SIGNATURE:	DATE:

Forms will not be processed until ALL documents are received:

Name Changes for Female Colleagues: Submit SSN card with married name.

Marital Status Changes: Attach Marriage License, Divorce Decree or Death Certificate.

Delete Eligible Family Members: Attach Statement of Termination of Domestic Partnership, Divorce/Death Certificate, if applicable.

Add Eligible Family Members:
Attach Birth Certificate, Marriage License, Verification of Termination of Coverage (HIPAA form) or Domestic Partner Affidavit of Eligibility.

Return form to: Hedy.DiSimoni@Infineum.com or
Infineum USA Inc.
LBTC 1033
1900 E. Linden Avenue
Linden, NJ 07036

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Please sign and date before mailing.