☐ 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 - - |
|---|---|---|---|---|
| | | | | |

**Please check the changes that you need to make to your member records: (Check all that apply.)**

- O Add spouse due to marriage
- O Terminate spouse due to divorce
- O Terminate spouse due to death
- O Add child-birth / adoption / stepchild
- O Terminate child due to death
- O Terminate child-no longer eligible
- O Change/Update Dependent status-handicap
- O Terminate dependent due to gaining other coverage
- O Enroll due to losing other coverage
- O Add dependent due to losing other coverage
- O Waive / Terminate coverage*
- O Gender Change
- O Other: _____

*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.

If the above change will affect your enrollment status, please check the appropriate box below. If it does not, leave blank"

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

| Street Address | City | State | Zip Code | Phone |
|---|---|---|---|---|
| | | | | |

| | Employee O Add O Waive O Change | Spouse O Add O Drop O Change | Dependent O Add O Drop O Change | Dependent O Add O Drop O Change |
|---|---|---|---|---|
| Social Security Number. | - - | - - | - - | - - |
| Previous Last Name | | | | |
| New Last Name | | | | |
| First Name Middle Initial | | | | |
| Sex (M/F) | O M O F | O M O F | O M O F | O M O F |
| Membership Status | O Single<br>O Married | O Spouse | O Child<br>O Stepchild<br>O Other<br>O Handicapped > 26 | O Child<br>O Stepchild<br>O Other _____<br>O 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. O 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** – (1) Email (2) Faxed Confirmation Delivery
- **For Open Enrollment must be sent by 11/5/2022 11:59** pm CST

☐ I elect to enroll in the **PPO** Medical/Rx, Vision & Dental Coverage as: O Employee Only O Employee & Spouse O Employee & Family O Employee & Child(ren)

☐ I elect to enroll in the CDHP Medical/Rx, Vision & Dental Coverage as: O Employee Only O Employee & Spouse O Employee & Family O 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 |
|---|---|---|---|
| | | | |

**After signing, make a copy for your records and return form by:**
Email: cliffs@umr.com
Fax: 855-307-8354
Questions call: 866-268-3489

Internal Use Only:
Status: O Approved O Incomplete O Late Termination/Change
Date_____ Initials _____
Notes:_____