

## 2020 Non-Union Craft Change of Coverage Form

**PROOF OF QUALIFYING LIFE EVENT MUST BE ATTACHED TO THIS FORM.**

Qualifying life event changes must be made within 31 days from the date of the event.

For the birth of a baby the deadline is 90 days after the baby's date of birth.

Please direct any questions to Mortenson's HR Service Center at [askHR@mortenson.com](mailto:askHR@mortenson.com) or 1-800-780-0642.

PLEASE PRINT CLEARLY

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Qualifying Event: \_\_\_\_\_ Date of Event: \_\_\_\_\_  
(marriage, separation, divorce, birth/adoption, loss of coverage, change in spouse employment)

### Medical & Dental Insurance

Please complete your medical and dental insurance elections. You are not required to enroll in Mortenson insurance. If you do not want to enroll in medical and/or dental insurance, please check the box for no coverage/ do not want this benefit.

Coverage Option	Medical Insurance Weekly Rate <small>(Includes pharmacy, vision, and short-term disability)</small> <b>REQUIRED</b>	Dental Insurance Weekly Rate <b>REQUIRED</b>
Team Member Only	<input type="checkbox"/> \$22.00	<input type="checkbox"/> \$2.77
Team Member + Spouse (Legally Married)	<input type="checkbox"/> \$56.00	<input type="checkbox"/> \$4.85
Team Member + Child(ren)	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$5.08
Family: Team Member + Spouse + Child(ren)	<input type="checkbox"/> \$81.00	<input type="checkbox"/> \$8.08
Team Member + Domestic Partner (DP)*	<input type="checkbox"/> \$56.00	<input type="checkbox"/> \$4.85
Team Member + Team Member's Child(ren) + Domestic Partner*	<input type="checkbox"/> \$81.00	<input type="checkbox"/> \$8.08
Team Member + Domestic Partner* + Domestic Partner's Child(ren)*	<input type="checkbox"/> \$81.00	<input type="checkbox"/> \$8.08
No Coverage	<input type="checkbox"/> I don't want this benefit.	<input type="checkbox"/> I don't want this benefit.

**\*Your Domestic Partner will not have insurance until you provide the required documentation below. Please call 800.780.0642 to start this process.**

1. Copies of both partners' driver's license confirming the same address.
2. Copies of a lease, mortgage, deed or 12 months of utility bills showing both partners as parties to the transaction.
3. Copies of documentation providing financial interdependence (joint checking account, loans, designation of domestic partner as beneficiary for life insurance, retirement, or will.)
4. Signed Statement of Domestic Partner form.

Team members are responsible to pay income taxes on the value of the domestic partner benefits. Please consult a tax advisor if you have any questions about the tax treatment of your domestic partner benefits.

### Dependent Information – Room for additional dependents can be found on the back

If you added your spouse, domestic partner, or children to medical or dental insurance above please list these individuals below. This information is required before your dependents' insurance starts.

First Name	Last Name	Date of Birth	Gender (M, F)	Social Security # <b>REQUIRED</b>	Relationship (Child, Spouse, Domestic Partner (DP), or DP's Child)

## Company Paid Life Insurance

All non-union craft team members receive \$5,000 in company paid life insurance. If you enroll in medical insurance your company paid life insurance increases to a total of \$25,000. Please provide the name(s) of the person(s) you would like to receive your life insurance death benefit.

Primary Beneficiary(ies) <b>REQUIRED</b>				
Full Name	Address	Social Security Number	Percent of Benefit	Relationship
1.				
2.				
3.				
<i>Percentage of benefit must equal 100%. Use only whole numbers. Do not use decimals such as 33.3%.</i>			Total: 100%	

If the primary beneficiary(ies) listed above die(s) before you, life insurance payment will be made to the secondary beneficiary(ies) listed below, if any.

Secondary Beneficiary(ies) <b>OPTIONAL</b>				
Full Name	Address	Social Security Number	Percent of Benefit	Relationship
1.				
2.				
3.				
<i>Percentage of benefit must equal 100%. Use only whole numbers. Do not use decimals such as 33.3%.</i>			Total: 100%	

You can change beneficiary(ies) at any time. If you wish to make changes or have any questions, please contact Mortenson's HR Service Center at 800.780.0642 or [askHR@mortenson.com](mailto:askHR@mortenson.com).

Additional Dependents					
If you added your spouse, domestic partner, or children to medical or dental insurance above please list these individuals below. This information is required before your dependents' insurance starts.					
First Name	Last Name	Date of Birth	Gender (M, F)	Social Security #	Relationship (Child, Spouse, Domestic Partner (DP), or DP's Child)
				<b>REQUIRED</b>	

Craft workers assigned to Davis-Beacon projects may experience a reduction in hourly wage rates upon commencement of benefit coverage. Project supervisors will provide specific information regarding the cost of such benefits before enrollment.

**If coverage is elected, I understand that a portion of the monthly premium is my responsibility. I authorize M.A. Mortenson Company to deduct from my pay any contributions to the cost of this coverage.**

\_\_\_\_\_  
Team Member Signature

\_\_\_\_\_  
Date