☐ QUALIFIED LIFE EVENT ☐ OPEN ENROLLMENT ☐ NEW HIRE ENROLLMENT

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.)

○ Add spouse due to marriage
○ Terminate spouse due to divorce
○ Terminate spouse due to death
○ Add child-birth / adoption / stepchild
○ Terminate child due to death
○ Terminate child-no longer eligible
○ Change/Update Dependent status-Handicap
○ Terminate dependent due to gaining other coverage
○ Enroll due to losing other coverage
○ Add dependent due to losing other coverage
○ Waive - $3,600 waiver payment prorated on a pay period basis

ONLY COMPLETE THE SECTIONS THAT APPLY TO CHANGES IN YOUR MEMBERSHIP RECORDS:

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
Membership Status	○ Single ○ Married	○ 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 11/5/2020 11:59 pm CST (1) Email (2) Faxed Confirmation Delivery

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

☐ 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	ArcelorMittal Business Unit/Location

- Return completed and signed form & copies of documents to UMR. Questions Call: 1-866-268-3489
- Mail to UMR – ArcelorMittal, Enrollment Services, 115 W Wausau Ave, Wausau, WI 54401
- Or Email to cliffs@umr.com or Fax to 855-307-8354

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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
   - Anthem 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* dependent, Birth Certificate and Social Security Card
9. Waive Coverage
   - Proof of other coverage, including coverage start date
10. Disenrollment in Medicare Part A
    - Disenrollment document provided by the Social Security Office

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 11/5/2020 11:59 pm CST
Acceptable Proof of submission (1) Email (2) Faxed Confirmation Delivery