AIARC
Association of International Agricultural Research Centers

901 North Washington Street, Suite 706
Alexandria, VA 22314–1535, United States
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IARC Insurance Plan Change Form

This form is used to make changes to your existing insurance coverage and/or dependent information. Please complete this form; sign and date; and return the form to your Center's HR Department for the Center Authorized Representative's signature to approve the requested change. Your Center will forward this form to AIARC. Please refer to the instructions on the back of this form to assist you.

1. Participant Name: (Surname, First, Middle)	**2. Date of Birth:** (dd/mm/yyyy)
3. Permanent Address:	
Town: **Region/State:** **ZIP/Postal Code:** **Country:**	
4. Personal Email Address: **Personal Telephone Number:**	**5. Gender:** ☐ **Male** ☐ **Female**

Change of Insurance Coverage - Complete this section only if you are changing your existing coverage

6. Change Coverage Type: (check only one box)
☐ Active ☐ Bridging
Retiree Intl. -- ☐ <65yrs ☐ 65+yrs
Retiree U.S. -- ☐ <65yrs ☐ 65+yrs; Are you enrolled in Medicare Part A & B? ☐ Yes ☐ No

7. Change Family Status: (check only one box)
☐ Single ☐ Family ☐ Retiree + Spouse ☐ Terminating Employment
☐ Add/Cancel Dependent (s)
☐ Continue Dependent(s) medical coverage after death of an Employee/Retiree (provide dependent(s) information in Box #8)

8. Dependent(s) information – To change/enroll eligible dependent(s), please complete the following information:

Coverage Add	Cancel	**Dependent Name** (Surname, First Name, Middle Initial)	**Relationship to Participant**	**Gender**	**Date of Birth** (dd/mm/yyyy)	**Other Insurance** Yes	No
☐	☐		-	-		☐	☐
☐	☐		-	-		☐	☐
☐	☐		-	-		☐	☐
☐	☐		-	-		☐	☐
☐	☐		-	-		☐	☐

9. Beneficiary Information - To change your existing Life and Accidental Death & Dismemberment beneficiaries, you will need to complete a new Beneficiary Designation Form.

10. Special Remarks

11. I hereby request change(s) to my existing insurance coverage within the IARC Insurance Plan for which I am an existing Participant. As affirmed at my enrollment, I agree to abide by the rules that govern the various types of insurance that comprise the IARC Insurance Plan as stated in the respective Plan Documents. I understand that the AIARC Board, in its sole discretion, reserves the right to change the benefits offered in the Plan at any time.

My signature below affirms that all information and statements provided on this form are accurate and true. I understand that misstatements, misrepresentations, or omissions may result in my insurance coverage being void as of its effective date with no benefits payable. Further, I have read and understand the Fraud Notice below:

Fraud Notice: Any Plan participant who intends to defraud or knowingly facilitates fraud against an insurer by submitting a request for enrollment (or change of enrollment) or by filing a claim containing false or deceptive information shall be terminated from the IARC Insurance Plan, which also may result in criminal charges.

Participant Signature: **Date: (dd/mm/yyyy)**

For Center's Use Only

12. Center Name:	**13. Coverage Effective Date:** (dd/mm/yyyy)
14. Signature of Center Authorized Representative:	**Date**: (dd/mm/yyyy)

For AIARC: Enrolled in ☐ Cigna ☐ CPAS	AIARC ID#	Coverage Class#	Cigna Ins#

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IARC Insurance Plan Change Form Instructions

(Form must be completed and signed by both participant and Center Authorized Representative)

EMPLOYEE: ***Please complete Items 1-10 and provide your signature in item 11.***

Item 1: Participant Name - If your name has changed, please provide your new full legal name. This name should match the name on your passport.

A copy of an official government document (i.e., passport) or a marriage certificate must be provided to AIARC to validate the change.

Items: 2 – 5: Enter required information.

Item 6: Change Coverage Type - Choose an insurance coverage type based on the categories below. For more information, refer to Eligibility for Plan Benefits in the IARC Medical Plan Brochure.

- **Active–** a Participant who is employed (actively working) at a Center and is currently enrolled in the IARC Insurance Plan.
- **Deceased Employee –** If the participant is deceased, indicate the date of death in Item #10 - Special Remarks.
- **Bridging –** a Participant who has terminated employment from the Center and has been enrolled only as a full-time or part-time employee in the IARC Medical Plan for at least the two most recent consecutive years (24 months) immediately prior to termination. *Please note that time enrolled in other employment classifications (e.g., consultant, short-term, etc.) will not count in the calculation for eligibility of bridging coverage.* For more information on the eligibility requirements for bridging coverage, refer to the AIARC.org website at Medical/Bridging-Retiree-Medical.
- **Retiree –** a Participant who is retired from the Center, is at least 60 years old, and has been only enrolled as a full-time or part-time employee in the IARC Medical Plan for at least 10 years (120 months) including the five consecutive years (60 months) immediately prior to his or her retirement. *Please note that time enrolled in other employment classifications (e.g., consultant, short-term, etc.) will not count in the calculation for eligibility of retiree coverage.* For more information on the eligibility requirements for retiree coverage, refer to the AIARC.org website at Medical/Bridging-Retiree-Medical.
- Indicate if you will be a retiree living in the U.S. or outside of U.S. If you are a retiree living in the U.S. and are 65 years or older, indicate if you are enrolled in the U.S. Medicare A & B. If you are eligible for U.S. Medicare, you must enroll in both parts A& B. If you enrolled in Medicare, you are required to provide a copy of your Medicare A & B card to AIARC.

Item 7: Change Family Status - Select the appropriate change in your coverage status.

Item 8: Dependent(s) information - To make changes to your dependent's coverage, you will need to complete this section.

- To **Add** dependent coverage, check the "Add Coverage" box, and enter the required information under each item.
- To **Cancel** any of the currently covered dependents, check the 'Cancel Coverage" box and enter the required information. *You must notifyyour Center within 25 days if you cancel a dependent from the Plan.*
- When **changing dependent** coverage, please use the following relationship to the participant: Husband, Wife, Partner, Child, DivorcedSpouse, or Other (If relationship is "other" explain in Item 10 - Special Remarks).
- Please select an answer to indicate if your dependent is covered by other insurance or Medicare.
- Children upon reaching age 26 are not eligible for coverage unless they are handicapped. For more information, refer to Eligibility for Plan Benefits in the IARC Medical Plan Brochure.

Item 9: Beneficiary Information – Please note that to change your existing beneficiaries, you will need to complete a new Beneficiary DesignationForm. Beneficiaries are those to whom any financial benefit will be paid in the event of your death. A change in beneficiary designations will not be processed until AIARC receives the updated form. Please note that this form is **only** for the IARC Insurance Plan.

Item 10: Special Remarks - Use this section to further explain any item.

Item 11: Participant Signature - Sign and date the form and submit original to your Center's HR Department for the Authorized Representative'sapproval/signature.

For Center's Use Only: The Center Authorized Representative must *complete items 12-14 and must provide signature to validate this form.*

Item 12: Enter Center's name.

Item 13: Effective Date of Change – Enter the effective date for the change in coverage type and/or status type. (See Enrollment and Effective Date Section in IARC Medical Plan Brochure). Examples include:

- In the event of marriage, new coverage is effective on the latter of the date of marriage or the date the enrollment form for the spouse wassubmitted to the Center by the Participant. A copy of the marriage certificate is required to be submitted to AIARC.
- New coverage for children is effective on the date of birth or adoption. A copy of a birth certificate or adoption document is required to besubmitted by the employee to AIARC.
- In cases of domestic partnership, new coverage for the partner (and his/her eligible dependents) is effective upon the date of approval bythe Center.
- For Bridging and Retiree options, the effective date is the 26th day after the end of employment date.

Item 14: Center Authorized Representative Signature - This form must be signed and dated by the Center Authorized Representative. Changeswill not be effective until AIARC receives a copy of this original signed form by email from the Authorized Representative.

For AIARC Use only: AIARC will complete the following shaded items on the form. Please do not enter any information in these boxes. - AIARC ID#, Cigna Insurance #, Center Plan # Plan Status #, and Insurance Coverage Class.