PTE 2021 Qualified Status Change Form

Medical, Dental, Vision, FSA, Dependent Life

If you experience a Qualified Status Change Event, complete this form and submit it to the Benefits Team by mail, email, scanning, or fax as indicated below. All changes and appropriate documentation must be received in the Benefits Office within **forty-five (45) days** from the date of the qualifying event, and the change made must be consistent with the type of change in status you have. Adding/changing coverage could result in an increase/decrease in your premiums. Additional premiums owed are your responsibility and will be collected. Please review the chart on the back side of this form to determine the amount of increase/decrease. Please provide the date of your Qualified Status Change Event next to the type of event you experienced. The effective date of the change is the date the Benefits Department received this complete, signed form and the required documentation (see back page).

Associate Information

Associate's Name (first name, last name) | Daytime Phone Number | Email Address

Associate Number | XXX-XX- Social Security Number (last four only)

Qualified Status Change Event

Event Type (choose one from the list on back of this form)	**Event Date**	**Required Documentation** (see list on back of this form)

Health and Life Insurance Plan Changes

To add, delete, or make a change to plans, please complete the section below. Indicate the plan name under each coverage type selected (ex: PPO1, PPO2, BIND, HDHP, Dent1, Dent2, DHMO, VSP). **Incomplete forms will not be processed and dependent SSN's are required by federal law. If adding a newborn, please submit this form within 45 days of birth and supply the SSN by calling benefits as soon as received.**

A=add D=delete	Name	Relationship	Gender	Date of Birth	Social Security Number (required field)	Medical	Dental	Vision

IF adding a Spouse to medical coverage and their employer offers a similar health plan, the Spousal surcharge of $20.00 will be charged in addition to the premium. Please X the appropriate box below.

☐ **Spouse does have comparable coverage**

☐ **Spouse does Not have comparable coverage**

Flexible Spending Account Changes

Additions/changes will be made to the remaining pay periods in the year to make your total contributions match your new annual goal. **additional rules may apply

Medical Flexible Spending Account Add/Change my annual goal limit to: _____

Dependent Day Care Flexible Spending Add/Change my annual goal limit to: _____

Health Savings Account--HDHP only Add/Change my per pay period amount: _____

The HSA amount selected carries over until you make a change. By signing up for the HDHP with HSA, I confirm I have read page 3 of this document and agree to the conditions explained by Optum Bank.

The above information is true. I understand that giving false information can result in disciplinary action and may result in loss of benefits. I authorize the preceding changes and any retroactive payroll deductions required on a post-tax basis.

I understand coverage will be effective the date the Benefits Department receives required documentation for the qualified change in status. The effective date for the birth or adoption of a child will be the child's date of birth or adoption placement date.

Associate Signature _____ Date _____

Mail: PetSmart Benefits Team - 19601 N. 27th Ave., Phoenix, AZ 85027 OR Fax: 1-800-738-9917

Questions: PetSmart Benefits Team: 1-866-263-8411 or benefits@petsmart.com

*****PLEASE EMAIL OR CALL TO VERIFY RECEIPT OF YOUR FAX AND DOCUMENTATION*****

If you provide your email address or phone number we can verify the forms have been received

For additional questions or more information visit our website at benefits.petsmart.com

Required documentation for Qualified Status Changes

Your requested changes will not go into effect until the required documentation below is provided to the Benefits Team and must be received within 45 days of the event date. Changes after 45 days will not be processed.

Allowable Qualified Status Changes	Verification Required (submit with this form)	Coverage Effective
Marriage ****Spousal surcharge may apply**	Copy of the marriage certificate showing spouse's name and date of marriage.	Starting the date your completed form and required documentation is received.
Divorce	Copy of the Divorce Decree (first and last page only indicating effective date).	Starting the date your completed form and required documentation is received.
Termination of Domestic Partnership-this will end the relationship status for this dependent in our HR system.	Completed Termination of Domestic Partnership form (found online at benefits.petsmart.com)	Starting the date your completed form and required documentation is received.
Birth of a child	Birth certificate or documentation on hospital letterhead indicating birth date and showing you as a biological parent. (Please provide SSN as soon as it is received).	Starting on the child's Date of Birth
Adoption of a child or establishment of legal guardianship	Proof of legal adoption or guardianship.	Starting on the adoption placement date.
Death of a dependent	Copy of the death certificate.	Starting the date your completed form and required documentation is received.
Adding PetSmart coverage due to loss of coverage under another plan	Documentation to prove loss of coverage within the past 45 days and effective date of loss. Also, if adding dependents we will need proof of spouse and/or child eligibility with a marriage or birth certificate for each dependent added.	Starting the date your completed form and required documentation is received.
Cancelation of PetSmart coverage due to gain of coverage under another plan for dependents and/or yourself	The "event date" on the front side of the form is the first day you will have other coverage; please be sure to enter the correct date and list all the dependents ***including yourself*** that you are cancelling coverage for. A copy of documentation to prove gain of other coverage in the past 45 days is required.	Starting the date your completed form and required documentation is received.
Unpaid leave of absence	No verification required- effective the leave of absence start date.	Starting the date your completed form and required documentation is received.
Life Insurance Beneficiary	Submit updates to the beneficiary for your life insurance by completing a new beneficiary designation form found on benefits.petsmart.com. Changes to life insurance elections indicated on the front of this form does not include a change to your designated beneficiary.	Starting the date your completed form and required documentation is received.

****If your spouse is eligible for comparable health insurance and you enroll them in our medical plan you will pay an additional $20.00 per week spousal surcharge. See benefits website for further explanation. Spousal surcharge is not refundable.**

2021 Weekly Associate Contributions

	Medical				Dental			Vision
Coverage level	PPO 1	PPO 2	Bind	HDHP	Plan 1	Plan 2	DHMO	Plan
Associate Only	$61.45	$44.11	$22.17	$22.17	$6.91	$3.04	$2.97	$1.66
Associate + Spouse	$146.62	$112.06	$84.87	$84.87	$13.38	$6.08	$6.52	$3.33
With Spousal surcharge	$166.62	$132.06	$104.87	$104.87				
Associate + Child(ren)	$126.98	$96.85	$73.21	$73.21	$15.21	$6.69	$7.65	$3.33
Associate + Family	$218.71	$167.78	$127.65	$127.65	$22.82	$10.02	$11.66	$5.00
With Spousal surcharge	$238.71	$187.78	$147.65	$147.65				

Weekly premiums will be owed back to the effective date of the event.
If you are salaried and paid biweekly, multiply the amount by 52 and then divide by 26.

Once your qualified status change has been processed, please verify the change on your HRConnect account under 'Benefits Participation Overview'. Please notify the Benefits Team immediately if you find any discrepancies.

Questions: PetSmart Benefits Team: 1-866-263-8411 or benefits@petsmart.com
For additional questions visit our website at benefits.petsmart.com

INFORMATIONAL PAGE ONLY. YOU DO NOT NEED TO FAX BACK TO BENEFITS.

Authorized Agent Agreement PetSmart

By selecting the HDHP with HSA account, I appoint PetSmart as the agent for the purpose of opening and administering a health savings account (HSA) on my behalf. I also acknowledge and certify that:

• I wish to establish a health savings account (HSA) with Optum Bank® as custodian.
• I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I understand and agree that my HSA will be opened and governed by Optum Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with Optum Bank's Truth in Savings New Account Disclosure, Privacy Notice and Schedule of Fees.

• I authorize Optum Bank to provide information about my HSA, including my account number, to my employer and those acting on behalf of my employer or Optum Bank, in connection with the establishment and maintenance of my HSA.

• I acknowledge that my employer and all others acting on behalf of my employer, may provide information on my behalf to establish and maintain my HSA and authorize my employer and its designee to take such action deemed necessary and appropriate by my employer to administer my HSA, including, but not limited to, making deposits and correcting errors where necessary.

• I understand my monthly account statements will be made available to me electronically. I agree to notify Optum Bank if I wish to have statements mailed to my home address.
• I understand that I have requested a MasterCard® Debit Card.

• I certify that the information provided in my application is true and complete.

• I certify that I have received or viewed the Bank's statement of the hardware and software requirements for access to and retention of electronic records and that I have the ability to access the Bank's website where electronic statements and other documentation are stored. I instruct the Bank, unless otherwise notified and instructed by me, to provide the Custodial and Deposit Agreement and all other HSA notices, disclosures and information related to and governing my HSA to me online at optumbank.com. Access information is listed below.

• I agree that Employer will remain my agent unless and until Employer and the Bank receive notice that the appointment of Employer as my agent has been terminated, that I am no longer employed by Employer, or that I am no longer an HSA eligible individual; or I receive a notice from the Bank that my application for an HSA has been declined.

PER THE USA PATRIOT ACT: To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

To view the Optum Bank's hardware and software requirements, instructions for viewing and downloading copies of electronic documents, and instruction for updating an email address, follow the link below:
https://www.optumbank.com/content/dam/optumbank/resources/ns/238-Hardware-and-Software-Requirements.pdf

Health savings accounts (HSAs) are individual accounts offered or administered by Optum Bank®, Member FDIC, and are subject to eligibility and restrictions, including but not limited to restrictions on distributions for qualified medical expenses set forth in section 213(d) of the Internal Revenue Code. State taxes may apply. This communication is not intended as legal, investment or tax advice. Please contact a competent legal, investment or tax professional for personal advice on eligibility, investments, tax treatment, and restrictions based on your individual financial situation, goals, and objectives. Federal and state laws and regulations are subject to change.