

How to remove a dependent from your benefits

1. From Workday homepage, under Your Top Apps, click View all Apps,

 [View All Apps](#)

Select the "Benefits and Pay" icon



Benefits and Pay

2. Under **Change**, select **Benefits**.

Change

Benefits

Beneficiaries

Dependents

Retirement Savings

1095-C Printing Election

3. Select **Change Reason** (e.g., Employee or Dependent Gains/Loses Other Coverage)

Change Reason *

- ☐ Beneficiary Change
- ☐ Birth/Adoption of a Child
- ☐ Change HSA Contributions
- ☐ Death of Spouse/Child
- ☐ Divorce
- ☒ Employee or Dependent Gains/Loses Other Coverage
- ☐ Marital Status - Marriage
- ☐ Retirement Contribution Change
- ☐ Spouse Gains / Loses Coverage from Another Source

4. Enter effective date of change in **Benefit Event Date**.

Benefit Event Date * MM/DD/YYYY 

5. Once **Benefit Event Date** is entered, **Submit Elections By** will automatically populate.

Benefit Event Date * 05/01/2022 

Submit Elections By 05/31/2022

Benefits Offered

- Child Life
- Dental
- Dependent Care FSA
- Healthcare FSA
- Health Savings Account
- + More (4)

6. Attached supporting documentation.

Attachments

Drop files here

or

Select files

7. Click **Submit**.

Submit

Save for Later

Cancel

8. Click **Open**.

You have submitted

Up Next: Robert Smith | Change Benefit Elections

[View Details](#)

Open

9. Click **Let's Get Started**.

Change Benefit Elections

Initiated On 05/24/2022

Submit Elections By 05/31/2022

Let's Get Started

10. Click **Manage** under the benefit you would like to update.

Health Care and Accounts

 Medical Florida Blue HDHP BlueOptions Cost per paycheck: \$164.78 Coverage: Family Dependents: 3 Manage	 Dental MetLife Dental DPO Enhanced Cost per paycheck: \$55.35 Coverage: Family Dependents: 3 Manage	 Vision EyeMed Vision Care V15 Cost per paycheck: \$2.94 Coverage: Family Dependents: 3 Manage
 Health Savings Account Health Equity Contribution per paycheck: \$0.00 Manage	 Healthcare FSA Waived Enroll	 Dependent Care FSA Waived Enroll

11. Confirm benefit plan, and click **Confirm and Continue**.

Plans Available

Select a plan or Waive to opt out of Medical. The displayed cost of waived plans assumes coverage for Family.

3 items

*Selection	Benefit Plan Details	You Pay (Biweekly)	Company Contribution (Biweekly)
☒ Select ☐ Waive	Florida Blue HDHP BlueOptions	\$164.78	\$723.90
☐ Select ☒ Waive	Florida Blue HMO BlueCare	\$195.68	\$714.98
☐ Select ☒ Waive	Florida Blue PPO BlueOptions	\$394.86	\$635.89

Confirm and Continue

Cancel

12. Deselect dependent(s) you are removing from coverage.

Dependents

Add a new dependent or select an existing dependent from the list below.

Coverage ★ Family

Plan cost per paycheck \$164.78

Add New Dependent

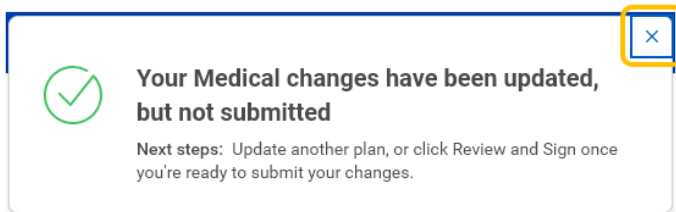
3 items

Select	Dependent	Relationship	Date of Birth
☒	Eve Smith	Child	01/26/1999
☒	Barbara Smith	Child	07/16/2002
☒	Susanne Smith	Spouse	05/14/1970

13. Click **Save**.



14. Once saved, you will receive confirmation. Click the **X** to return to benefit elections.



15. You will see change reflected on the benefit tile.



Medical
 Florida Blue HDHP BlueOptions

Cost per paycheck	\$101.04
Coverage	Employee + Child(ren)
Dependents	2

[Manage](#)

16. Repeat steps 10 - 15 for all benefits you wish to change.

17. Click **Review and Sign** once all changes are made.

Review and Sign

Save for Later

18. Review the summary to ensure all benefits are correct.

Selected Benefits: 5 items

Plan	Coverage Begin Date	Reduction Begin Date	Coverage	Dependents	Beneficiaries	Cost
Medical Florida Blue HDHP BlueOptions	06/01/2022	06/01/2022	Employee + Child(ren)	Barbara Smith Eve Smith		\$101.04
Dental MetLife Dental DPO Enhanced	06/01/2022	06/01/2022	Family	Barbara Smith Eve Smith Susanne Smith		\$55.35
Vision EyeMed Vision Care VHS	01/01/2020	01/01/2020	Family	Barbara Smith Eve Smith Susanne Smith		\$2.94
Health Savings Account Health Equity	01/01/2020	01/01/2020	\$0.00 Annual			Included
Supplemental Life and AD&D Unum STD/LTD/Life (Employee)	01/01/2020	01/01/2020	\$50,000		Maria Amaro	\$9.23

19. If all benefit elections are correct, check **I Agree**.

Electronic Signature**Legal Notice: Please Read**

Your name and Password are considered your "Electronic Signature" and will serve as your confirmation of the accuracy of the information being submitted. When you check the "I Agree" checkbox, you are certifying that:

- You understand and approve the enrollment as indicated above. You hereby authorize the company to deduct from your earnings the amount of your premiums or other contributions (if any) for the benefit options elected above.
- You understand and acknowledge that under the Internal Revenue Code regulations rules, you may not change your benefit elections during the calendar year unless you experience a qualified change in status.
- You understand that you will not pay income tax or FICA tax on my medical, dental, vision, and Flexible Spending Account contributions. These benefits are paid through the Flexible Benefits Plan on a pre-tax basis.
- Company provided life insurance that exceeds \$50,000 may be subject to imputed income.
- Each year, during the annual enrollment period, you will have the option to change certain coverages whether or not you have had a qualified change in status event during the calendar year.
- If you decline medical insurance enrollment for yourself or your dependents, including your spouse, because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you request enrollment within 31 days after your other coverage ends. In addition, if you have a new spouse or dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself, your spouse and your dependents, provided you request enrollment within 31 days after the marriage, birth or adoption.

REPRESENTATION: I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers contained in this application are representations, not warranties, and are true, complete, and correctly recorded. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR LIFE AND CRITICAL ILLNESS):** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Manager, insurance company, MIB, Inc. or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any information. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I acknowledge receipt of the Important Notice About Privacy and MIB notice form. A copy of this authorization is as valid as the original. This authorization applies to any minor dependent on whom insurance is requested. This authorization is valid for 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL, in writing of my desire to do so.

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I Agree ☐

20. Click **Submit**.

Submit Save for Later Cancel

21. Click **Done**.

Submitted

You've submitted your elections.

View 2022 Benefits Statement

Done

22. Benefit change must be approved by Employee Services. Once change has been approved your benefits will be updated.