

# Instructions for Medical Benefits Cancellation form – due to reduction in hours



This form may be used to drop your pre-tax medical coverage in order to enroll in other medical coverage.

However, you must meet three requirements to be eligible to drop coverage:

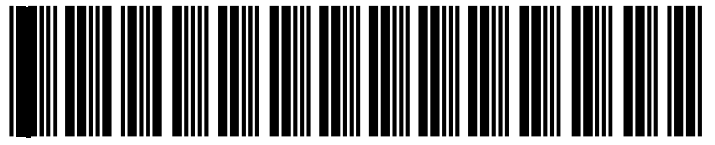
1. You must be currently enrolled in Macy's, Inc. medical coverage.
2. You must have had a work schedule change that affects the hours you are expected to work, so you are now reasonably expected to be paid less than an average of 30 hours per week.
  - a. For example, an associate in a full-time hourly position transfers into a part-time position where he/she is reasonably expected to work an average of less than 30 hours per week.
  - b. Or an associate who is currently in schedule option 1 is moved to schedule option 4. He or she may use this form.
  - c. If a part-time associate regularly works an average of 30 hours or more per week and was offered medical coverage suddenly begins to work an average of 20 hours per week he/she is not eligible to use this form.
3. You must intend to enroll in medical coverage providing minimum essential coverage either through another employer, spouse's employer or the Health Insurance Marketplace.

This form **MUST** be received within 31 days of the employment status change. It will not be accepted after 31 days.

Once the form has been processed, your coverage will end as of the date of your status change. (For example, if you changed schedules on Nov. 13 and submitted this form 10 days later, your coverage would end effective Nov. 13.) Also, you will only be able to drop your and your spouse/DP's medical coverage and HSA. You will not be able to discontinue a Health Care or Limited Flexible Spending Account.



Benefits



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### Verification of Enrollment in Other Medical Coverage Due to a Qualifying Change in Employment Status

This form is required only for those associates who (1) are enrolled in Macy's, Inc. medical coverage and now wish to cancel their Macy's, Inc. medical coverage because the associate has had a change in employment status event that results in the associate now being reasonably expected to work less than an average of 30 hours per week, and (2) wish to enroll in another plan providing minimum essential coverage. Associates needing to make coverage changes to pre-tax medical coverage due to a qualified change in family status or Marketplace open or special enrollment period should call HR Services and complete the appropriate "Certification of Change in Family Status Form" or "Verification of Marketplace Enrollment" form.

To cancel medical coverage due to a change in employment status that results in a schedule option where you are reasonably expected to work less than 30 hours each week:

- (1) **You must complete this "Verification of Enrollment in Other Medical Coverage Due to a Qualifying Change in Employment Status" form and fax it to 1-513-573-2163 (Tie Line is 8-11-4-003-2163), or mail it to: HR Services, P.O. Box 8083, Mason, OH 45040-5300.** This form **MUST** be **received** by HR Services within 31 days of the effective date of your change in employment status. If you have any questions, contact HR Services at 1-800-234-MACY (6229).
- (2) **HR Services will contact you to advise how to cancel your Macy's, Inc. health care coverage through My IN-SITE. Please note that return of this "Verification of Enrollment in Other Medical Coverage Due to a Qualifying Change in Employment Status" form alone does not guarantee cancellation of coverage.**

<b>Associate Information</b>	Associate Name:	Associate ID:	Preferred Daytime Phone Number:
	<b>Coverage Information</b>		
	Name of <b>New</b> Insurance Carrier (e.g., Cigna, Aetna, etc.):	New Coverage Begin Date:	

By signing below, I hereby certify the change in employment status indicated above and verify that I have enrolled, or intend to enroll, in another health care plan that provides minimum essential coverage, including a qualified health plan through the Health Insurance Marketplace, effective no later than the first day of the second month following the month that includes the date my Macy's, Inc. health care coverage ends. I understand HR Services will provide instructions regarding how I can cancel my Macy's, Inc. health care coverage. Further, I understand Macy's, Inc. reserves the right to request documentation of my enrollment in another qualified health care plan. If any of the above facts and certifications are incorrect, I understand that I may be prohibited from cancelling my Macy's, Inc. health care coverage, and I may be obligated to make up any employee deductions that were stopped inappropriately. Any misrepresentation or willful omission of information may be cause for disciplinary action up to and including suspension or termination of coverage by Macy's, Inc., or dismissal from employment by Macy's, Inc.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_