

Qualifying Change in Status Request

Documentation Required. <i>Read the Terms and Conditions on the back of this form.</i>		Return to Human Resources within 60 days of the Event.	
1. Effective Date of Change/Enrollment:		2. Reason for Change(s) in Coverage (Check the box that best describes the reason for this action)	
Employee Number	Daytime Telephone Number ()	<input type="checkbox"/> Marriage/Divorce (please complete Name Change Form) <input type="checkbox"/> Loss of Eligible Dependent(s) <input type="checkbox"/> Gain of Eligible Dependent(s) <input type="checkbox"/> Death <input type="checkbox"/> Qualified Medical Child Support Order <input type="checkbox"/> Loss/Gain of Spouse or Employee Coverage (Employment Change) <input type="checkbox"/> Return From Leave of Absence	
Last Name	First Name Middle Initial		
Street Address			
Apt / Box / Route Number			
City / State / Zip Code			
3. Dependent Information – Please list each eligible dependent to be covered. Attach additional sheets if necessary.			
Dependent(s) Full Name	Social Security Number	Date of Birth	Relationship
4. Coverage Change(s) – Please Specify the level of coverage requested. Coverage Levels: E- (Employee Only), EC – (Employee + Child(ren), ES - (Employee & Spouse), EF - (Employee & Family), Waive - (No Coverage) Please submit Supporting Documentation and Creditable Coverage/HIPAA form			
Health Plan	Dental Coverage	Life Coverage (employee only coverage)	
What level of coverage are you requesting? _____ Spouse Employer: _____ Does employer offer Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	What level of coverage are you requesting? _____ <input type="checkbox"/> Standard Plan <input type="checkbox"/> Copay Plan Vision Coverage What level of coverage are you requesting? _____	Employees returning from Leave of Absence can re-enroll for life coverage, retaining their original coverage level. Re-enroll for Life Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence of Insurability is required	
Health Care/Dependent Care Spending Account		Disability Coverage (employee only coverage)	
<input type="checkbox"/> Enroll in DCSA: <input type="checkbox"/> Enroll in HCSA Bi-Weekly Contribution \$ _____ <input type="checkbox"/> Increase Contribution from \$ _____ to \$ _____ <input type="checkbox"/> Decrease Contribution from \$ _____ to \$ _____ <input type="checkbox"/> Discontinue Coverage Name of Day Care Facility _____		Employees returning from Leave of Absence can re-enroll for disability coverage, retaining their original coverage level. Re-enroll for Long Term Disability Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Re-enroll for Short Term Disability Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Evidence of Insurability is required	
5. Authorization I have read and agree with the Terms and Conditions provided with this form. I certify that the above information and any attachments are true and correct. I understand that any misrepresentation or falsification will subject me to penalties and possible termination . Employee Signature: _____ Date Signed: _____			
HR USE ONLY			
Request: <input type="checkbox"/> Approved <input type="checkbox"/> Denied Authorized by: _____ Comments: _____ _____			

TERMS AND CONDITIONS

Policy Information

The Flexible Benefits Program functions as an Internal Revenue Code, Section 125, "cafeteria plans". Under IRS regulations and Rules of the Summary Plan Document, benefit elections made by employees during Annual Enrollment are binding for the duration of the Plan Year. Only under limited conditions of a qualifying "Change in Status" are employees allowed to enroll/increase or cease/decrease some coverage outside Annual Enrollment. A benefit election change will only be permitted if approved by Human Resources.

General Information

This form is to be used by an employee who is requesting a change in benefits due to a qualifying "Change in Status". When a change in status occurs, the employee is to complete the applicable areas of this form and return it to Human Resources within 60 days of the event. If additional clarification is needed, please call the Employee Call Center at (239) 772-6500. Completed forms with documentation can be faxed to Human Resources at (239) 772-6565 or mailed via interoffice.

Effective Date of Change of Coverage

Changes will go into effect the date of the event or the return date from a Leave of Absence.

If you return to work from a Leave of Absence and fail to pay premiums while on leave, Reliance Standard Life Insurance Company requires proof of good health before your disability and life benefits are reinstated. Please contact Human Resources for the Evidence of Insurability form.

Qualifying Events/Acceptable Documentation

Events that may permit you to enroll or change one or more coverage options:

- a) you gain or lose a spouse; marriage certificate, divorce decree or death certificate.
- b) you gain or lose an eligible dependent; birth certificate, legal guardianship, adoption, student status or death certificate.
- c) your spouse or dependent becomes eligible for or loses coverage under another employer's plan, COBRA or a governmental plan; HIPAA certificate, other plan enrollment documentation with effective date and plan ID card.
- d) your change in residence causes you, your spouse, or dependents to gain or lose eligibility for coverage under your plan or another employer's plan.
- e) the cost of your Dependent Care increases or decreases significantly and your dependent care provider is not related to you, your spouse or your dependent; statement from day care showing change in amount and effective date.
- f) you, your spouse or your dependent gain or lose eligibility for Medicare or Medicaid.