PERSONAL
BENEFIT ELECTION CHANGE
REQUEST FORM

Employee _____ **SS#** _____

Employer: _____

Instructions

Step 1 Complete ***Employee Statement of Qualifying Event*** and attach applicable page to this request form.

Step 2 Determine what changes you can make by reviewing the ***Change in Status Matrix***.

- Locate the qualifying change in status code "SC code" listed on the ***Employee Statement of Qualifying Event*** form
- Locate that same status code "SC code" on the ***Matrix*** listed in the left hand column
- Follow across to the column listing the benefit plan class you are interested in changing
- Where the row and column meet, there you will find authorized changes you can make.

Step 3 Complete this ***Personal Benefit Election Change Request Form***

Step 4 Sign in the *Employee Signature* box and return to your benefits counselor within 30 days of the qualifying change in status event.

CHANGE IN BENEFIT ELECTION

PLAN CLASSES:
5.1 (Core Health)
5.2 (Non-Core Supplemental Health)
5.3 (Group Term Life)
5.4 (Short-Term Disability)
5.5 (Long-Term Disability)
5.7 (Health FSA)
5.8 (Dependent Care Assistance)
5.10 (Health Premium Reimbursement Account)
5.11 (Group Dental)
5.12 (Group Vision)
5.13 (AD&D)

☐ I WANT TO ELECT NEW BENEFIT(S)

Benefit	Option if Applicable (Employee Only, Family, etc.)	Plan Class (See above.)	Deduction Amount per Pay Period
			$
			$
			$

☐ I WANT TO TERMINATE BENEFIT(S)

Benefit	Option if Applicable (Employee Only, Family, etc.)	Plan Class (See above.)	Deduction Amount per Pay Period
			$
			$
			$

☐ I WANT TO REPLACE EXISTING BENEFIT WITH NEW BENEFIT

Benefit	Option if Applicable (Employee Only, Family, etc.)	Plan Class (See above.)	Deduction Amount per Pay Period
Replace:			$
With:			$

☐ I WANT TO CHANGE OPTIONS FOR ELECTED BENEFIT(S)

Benefit	Plan Class (See above.)	Replace Option	Deduction Amount per Pay Period	With Option	Deduction Amount per Pay Period
			$		$
			$		$
			$		$

☐ I WANT TO CHANGE RATES FOR A ELECTED BENEFIT

Benefit	Plan Class (See above.)	Option	From Deduction Amt per Pay Period	To Deduction Amt per Pay Period
			$	$

☐ **I WANT TO ELECT BENEFIT OPTIONS FOR QUALIFYING FMLA**

Instructions

If you selected SC 7.1.1 – **Beginning FMLA Leave** (#25) on the ***Employee Statement of Qualifying Event*** you now need to decide how you will pay your benefit premiums while you are on leave.

- List each applicable Benefit, Plan Class (found above) and check one payment option per benefit. Refer to the footnotes below for additional detail on each option

BENEFIT	PLAN CLASS	OPTIONS					
			Pay-As-You-Go		Catch Up		
		Prepay[1]	Pay Period[2]	COBRA[3]	Payroll Deduction[4]	Lump Sum[5]	Drop Coverage[6]

[1] Premiums may be pre-paid before going on FMLA leave (during same plan year) pursuant to your Cafeteria Plan.

[2] While on leave, you may elect to pay premiums to the Employer at the same time that they would be paid if by payroll deduction (with after-tax dollars)

[3] While on leave, you may elect to pay premiums to the Employer at the same time that they would be paid under COBRA which is typically once-a-month (with after-tax dollars)

[4] Upon return from leave, you may "catch up" on your premiums through payroll deduction with pre-tax dollars (if you return during same plan year). If you return after plan year has ended, you may "catch up" your premiums through payroll deductions with after-tax dollars.

[5] You may make a lump sum payment (with after-tax dollars)

[6] You may elect to drop coverage before going on leave.

SIGNATURES

Employee Signature Box

Attached is my ***Employee Statement of Qualifying Event.*** I hereby elect the benefit changes noted hereon and attest that these benefit change(s) is/are caused by and consistent with the qualifying change in status code "SC #_____". I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I also realize that the elections I have elected cannot be retroactive unless I am adding a new dependent and HIPAA special enrollment rights apply. I understand that the qualifying event and the resulting changes I have requested on this form must comply with my employer's plan, and the Plan Administrator has the sole discretion to make this determination. If my requested changes are denied, I understand that I will have 60 days to appeal the decision.

Employee Signature_____ Date_____

Employer Signature Box

Acceptance of Change Request

Process changes in benefit elections on Pay Period No. _____ Pay Date:_____

Authorized Signature:_____

Change Entry Record

Date Request Received:_____ Date Change Processed:_____

Processed by:_____ System Doc No.:_____

Signed:_____ Date:_____

EMPLOYEE
STATEMENT OF QUALIFYING EVENT

Instructions

- Locate your qualifying change in event & complete entire applicable section
- Pay close attention to the "SC" Code located in the right hand column
- Complete the Employee Certification Box with your signature & date
- Attach to your ***Personal Benefit Election Change Request Form***

QUALIFYING EVENTS

☐ **1. Marriage** SC 1.1.1

I was married as of (date) _____

Spouse Name: _____ SSN _____

☐ **2. Lost Spouse** SC 1.1.2

I lost a spouse as of (date) _____

Reason: ☐ Divorce ☐ Legal Separation ☐ Annulment ☐ Death of Spouse

Spouse Name: _____ SSN _____

☐ **3. Gained Dependent** SC 1.2.1

I have gained the dependent(s) listed below as of (date) _____

Dependent Name(s): _____

_____

Reason: ☐ Birth ☐ Adoption ☐ Legal Guardianship

☐ **4. Lost Dependent** SC 1.2.2

I have lost the dependent(s) listed below as of (date) _____

Dependent Name(s): _____

_____

Reason: ☐ Death ☐ Placement for Adoption

☐ **5. Employee Gained Eligibility Through Change In Employment** SC 1.3.1

I have gained eligibility under the Plan through a change in employment as of (date): _____

Change: ☐ Part-Time to Full-Time ☐ Hourly to Salary ☐ Back from Strike/Lockout
☐ Rehired after 30 days of termination ☐ Return from non-FMLA Leave after 30 days
☐ Other event: (describe): _____

Newly Eligible Benefits: ☐ All under Plan ☐ Specific Component(s) _____

_____

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____

☐ **6. Spouse/Dependent Gained Eligibility under their Employer's Plan through Change in Employment** SC 1.3.5

My spouse or dependent has gained eligibility under their employer's Plan through a change in employment as of (date): _____.

Newly Eligible Benefit(s): ☐ All under Plan ☐ Specific Component(s) _____

_____

Benefits Elected as a result: _____

_____ as of (date) _____

Name of ☐ Spouse ☐ Dependent _____

Change: _____ ☐ Hired ☐ Part-Time to Full-Time ☐ Hourly to Salary ☐ Back from Strike/Lockout

☐ Other event: (describe): _____

☐ **7. Spouse/Dependent Lost Eligibility under their Employer's Plan through Change in Employment** SC 1.3.6

My spouse or dependent has lost eligibility under their employer's Plan through a change in employment as of (date) _____ .

Lost Benefit(s): ☐ All under Plan ☐ Specific Component(s) _____

_____

Benefits Dropped as a result: _____

_____ as of (date) _____

Name of ☐ Spouse ☐ Dependent _____

Change: ☐ Terminated ☐ Full-Time to Part-Time ☐ Salary to Hourly ☐ Go on Strike/Lockout

☐ Other event: (describe): _____

☐ **8. Dependent Gains Eligibility under Employee's Plan** SC 1.4.1

My dependent has become eligible for my plan or one of its components as of (date) _____

Dependent Name: _____

Newly Eligible Benefit(s): ☐ All under Plan ☐ Specific Component(s) _____

_____

Reason for Eligibility: ☐ Attains Specified Age ☐ Becomes Single ☐ Becomes Student

☐ Other event: (describe): _____

☐ **9. Dependent Loses Eligibility under Employee's Plan** SC 1.4.2

My dependent is no longer eligible for my Plan or one of its components effective as of (date) _____

Dependent Name: _____

Lost Benefit(s): ☐ All under Plan ☐ Specific Component(s) _____

Reason for Ineligibility: ☐ Attains Specified Age ☐ Gets Married ☐ Ceases to be a student

☐ Other event: (describe): _____

☐ **10. Employee Gained Eligibility for Plan Component through Change of Residence** SC 1.5.1

A change in my residence has made me eligible one of Plan's components effective as of (date) _____ .

New Address: _____

Newly Eligible Component(s): _____

☐ **11. Employee Lost Eligibility for Plan Component through Change of Residence** SC 1.5.2

A change in my residence has made me ineligible for one Plan's components effective _____ .

New Address: _____

Newly Ineligible Component: _____

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____

☐ **12. Employee moves out of HMO Service Area** SC 1.5.3

I moved out of my HMO Service Area as of (date) _____ .

☐ **13. Spouse/Dependent Gained Eligibility for Plan Component through Change of Residence** SC 1.5.4

A change in my spouse's or dependent's residence has made them eligible for one of the components of my Plan effective as of (date) _____

New Address: _____

☐ Spouse ☐ Dependent Name: _____

Newly Eligible Component(s): _____

Election Resulting from Change: _____

☐ **14. Spouse/Dependent Lost Eligibility for Plan Component through Change of Residence** SC 1.5.5

A change in my spouse's or dependent's residence has made them ineligible for one of the components of my Plan effective as of (date) _____

New Address: _____

☐ Spouse ☐ Dependent Name: _____

Component(s) Dropped as a Result: _____

☐ **15. Day Care Provider Changed Rates** SC 2.1.3

The Day Care Provider for my child has changed rates as of (date): _____

Dependent Name: _____

Name of Day Care Provider: _____

Day Care Provider is ☐ my relative ☐ is not my relative.

Old Rates: _____ New Rates: _____

☐ **16. Individually Owned Policy Changed Rates** SC 2.1.3

My Individually Owned Policy has changed rates as of (date): _____

Policy Carrier Name: _____

Policy Number: _____ Policy Type: _____

Old Rates: _____ New Rates: _____

☐ **17. Employee Response to Significant Cost Increase** SC 3.1.1b

I understand my elected benefit _____

has had a significant cost increase.

☐ I understand that _____

has been categorized, as a similar coverage, and I would like to replace my current election with it.

☐ I understand that there is no similar coverage, so I would like to drop my current election.

☐ **18. Employee Response to Significant Cost Decrease** SC 3.2.1b

I understand that the (benefit) _____

has had a significant cost decrease.

☐ I would like to replace my current election of (benefit) _____ and elect the above benefit.

☐ I would like to add the above benefit.

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____

☐ **19. Employee Response to Significant Coverage Curtailment (without loss of coverage)** SC 4.1.1b

I understand the coverage under my elected benefit _____
has been significantly curtailed, but is not considered to be a loss of coverage.

☐ I understand that _____ has been categorized as a similar coverage, and I would like to replace my current election with it..

☐ **20. Employee Response to Significant Coverage Curtailment that is considered a loss of coverage** SC 4.1.1c

I understand the coverage under my elected benefit _____ has been significantly curtailed and is considered to be a loss of coverage

☐ I understand that _____ has been categorized as a similar coverage, and I would like to replace my current election with it.

☐ I understand that there is no similar coverage, so I would like to drop my current election.

☐ **21. New Day Care Provider for Employee's Dependent** SC 5.1.5

I have changed Day Care Providers for my child as of (date): _____
Previous Day Care Provider: _____
New Day Care Provider: _____
Old Rates: _____ New Rates: _____

☐ **22. Day Care Provider for Employee's Dependent has changed rates.** SC 5.1.6

The Day Care Provider has changed rates effective (date): _____
The Day Care Provider is not a relative.
Old Rates _____ New Rates: _____

☐ **23. Coverage has been Increased Under Another Employer Plan** SC 6.1.1

Coverage under (plan) _____
For (type of benefit) _____
Has been increased for ☐ myself, ☐ my spouse and/for ☐ my dependent(s) effective as of (date) _____
Dependent Names: (if applicable) _____

☐ **24. Coverage has been Decreased Under Another Employer Plan** SC 6.1.2

Coverage under (plan) _____
For (type of benefit) _____
Has been decreased for ☐ myself, ☐ spouse and/for ☐ dependent(s) effective as of (date) _____
Dependent Names: (if applicable) _____

☐ **25. Eligibility for Coverage has been Gained Under Another Employer Plan** SC 6.1.1

Eligibility has been gained (and benefit elected) under (plan) _____
For (type of benefit) _____
Coverage under that benefit will start for ☐ myself, ☐ my spouse and/for ☐ my dependent(s) effective (date) _____
Dependent Names: (if applicable) _____

☐ **26. Eligibility for Coverage has been Lost Under Another Employer Plan** SC 6.1.2

Eligibility has been lost (and benefit dropped) under (plan) _____
For (type of benefit): _____
Coverage under that benefit will stop for ☐ myself, ☐ my spouse and/for ☐ my dependent(s) effective (date) _____
Dependent Names: (If applicable) _____

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____

☐ **27. Spouse or Dependent Dropped/Decreased Elections under Their Cafeteria Plan during Open Enrollment** SC 6.1.3

My ☐ spouse ☐ dependent changed elections under their cafeteria plan during open enrollment effective (date) _____ .

The following benefits were dropped or decreased:

Benefit: _____ _____ ☐ Dropped ☐ Decreased

Benefit: _____ _____ ☐ Dropped ☐ Decreased

Benefit: _____ _____ ☐ Dropped ☐ Decreased

☐ **28. Spouse or Dependent Added/Increased Elections under Their Cafeteria Plan during Open Enrollment** SC 6.1.3

My ☐ spouse ☐ dependent changed elections under their cafeteria plan during open enrollment effective (date) _____ .

The following benefits were dropped or decreased:

Benefit: _____ _____ ☐ Added ☐ Increased

Benefit: _____ _____ ☐ Added ☐ Increased

Benefit: _____ _____ ☐ Added ☐ Increased

☐ **29. Employee Lost Coverage under Group Health Plan of a Governmental or Educational Institution** SC 6.1.4

I lost coverage under (Plan) _____ effective as of (date)_____

☐ Spouse ☐ Dependent Name _____

☐ **30. Spouse/Dependent Lost Coverage under Group Health Plan of a Governmental or Educational Institution** SC 6.1.4

My spouse/dependent lost coverage under (Plan) _____ effective as of (date)_____

Remember to complete the ***Benefit Payment Options while on FMLA*** form.

☐ **31. Beginning FMLA Leave** SC 7.1.1

I am going on FMLA effective _____

Remember to complete the ***Benefit Payment Options while on FMLA*** form.

☐ **32. Returning from FMLA Leave** SC 7.2.1

I am returning from FMLA effective _____

This notification only needs to be submitted if the employee revoked elections during the FMLA and wishes to reinstate the elections.

☐ **33. COBRA** SC 8.1.1

I have experienced a COBRA event for a benefit elected under Cafeteria Plan, and I remain an eligible participant in this Cafeteria Plan..

COBRA Event: _____ Effective as of (date):_____

Benefit: _____

☐ **34. COBRA** SC 8.1.2

My spouse/dependent has experienced a COBRA event for a benefit I have elected under my cafeteria plan.

Name of ☐ Spouse ☐ Dependent: _____

COBRA Event: _____

Benefit: _____

☐ **35. Judgment, Decree, or Order Requiring Employee to Provide Coverage for Dependent** SC 9.1.2

I have a Judgment, Decree, or Order requiring someone to provide coverage for my Dependent(s) .

Name of Dependent(s): _____

Coverage Required: _____

Coverage was provided as of (date):_____

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____

☐ **36. Judgment, Decree, or Order Requiring Another Person to Provide Coverage for Dependent** SC 9.1.2

I have a Judgment, Decree, or Order requiring someone else to provide coverage for my Dependent(s) effective as of (date)_ .

Name of Dependent(s): _____

Coverage Re uired: _____

Coverage Effective as of (date): _____

☐ **37. Employee Attained Eligibility for Medicare or Medicaid** SC 10.1.1

I have become eligible for ☐ Medicare ☐ Medicaid (other than coverage for pediatric vaccines).

My coverage is effective as of (date) _____ .

☐ **38. Spouse/Dependent Attained Eligibility for Medicare or Medicaid** SC 10.1.2

My spouse or dependent(s) has become eligible for ☐ Medicare and ☐ Medicare (other than coverage for pediatric vaccines).

The coverage is effective as of (date) _____

☐ Spouse ☐ Dependent Name: _____

☐ **39. Employee Lost Eligibility for Medicare or Medicaid** SC 10.2.1

I have lost my eligibility for ☐ Medicare and ☐ Medicare (other than coverage for pediatric vaccines) effective as of (date) _____ .

☐ **40. Spouse/Dependent Lost Eligibility for Medicare or Medicaid** SC 10.2.2

My spouse or dependent(s) has lost their eligibility for ☐ Medicare and ☐ Medicare (other than coverage for pediatric vaccines) effective as of (date) _____ .

☐ Spouse ☐ Dependent Name: _____

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____