Davis School District
45 East State Street, P. O. Box 588, Farmington UT 84025-0588

QUALIFYING STATUS CHANGE

A. EMPLOYEE INFORMATION

LEGAL LAST NAME	FIRST NAME	MIDDLE NAME OR MI	SOCIAL SECURITY	DATE OF BIRTH (mm/dd/year)
				/ /

Change of Address? NO ◯ YES ◯ | ADDRESS | CITY | STATE | ZIP CODE | GENDER ◯ M ◯ F | MARITAL STATUS ☐ Married ☐ Single

TELEPHONE NUMBER + AREA CODE ( )

If your spouse is a district employee and carry his or her own health plan, choose one health option with which you wish to continue:
◯ ***Continue with my individual health plan.*** ◯ ***Coordinate health plan with my spouse.***

B. QUALIFYING EVENT

ADD COVERAGE
Based on the following event:

- ☐ **New Born**
- ☐ **Adoption** (Attached Adoption Document)
- ☐ **Legal Marriage** (Attached Marriage License or Certificate)
- ☐ **Legal Guardianship** (Attached Dated Signed Court Order)
- ☐ **Loss of Other Coverage** (Attached Certificate of Creditable Coverage)
- ☐ **Other** ____________

DELETE COVERAGE
Based on the following event:

- ☐ **Divorce or Legal Separation** (Attached Divorce Decree or Legal Separation)
- ☐ **Death of Dependent**
- ☐ **Marriage of Dependent**
- ☐ **Dependent No Longer Eligible**
- ☐ **Other** ____________

*Spouse's signature is required if dropping him or her from coverage for reason other than divorce.

____
**Spouse Signature*

DATE OF EVENT

/ /
MM DD YEAR

This change form must be received by the Human Resources Office no later than thirty (30) calendar days of the qualifying event.

NAME CHANGE

FROM

TO

C. DEPENDENT(S) INFORMATION

LIST DEPENDENTS TO WHOM THIS CHANGE APPLIES

ADD OR DELETE	RELATION	LEGAL NAME FIRST, MIDDLE OR (MI), LAST NAME	GENDER M/F	DATE OF BIRTH MM/DD/YEAR	SOCIAL SECURITY NUMBER
A ◯ D ◯	Spouse				
A ◯ D ◯	Child				
A ◯ D ◯	Child				
A ◯ D ◯	Child				
A ◯ D ◯	Child				

D. REQUESTED ENROLLMENT CHANGE

HEALTH PLANS (Select One)	☐ Aetna Select Open Access ☐ Aetna Select Open Access *High Deductible and Aetna Form A*		☐ SHC SelectMed ☐ SHC SelectMed *High Deductible and SHC Form B*
DENTAL PLANS (Select One)	◯ Delta Dental Basic PPO		◯ Delta Dental Premier Plus PPO
OPTICARE "120B" (Select One)	☐ Single Coverage	☐ Two-Party Coverage	☐ Family Coverage
BASIC LIFE INSURANCE	◯ Employee Policy	◯ Spouse Policy	◯ Child(ren) Policy
AD&D *(Accidental Death & Dismemberment)*	☐ Employee benefit only $________ amount. *(Employee only benefit of $10,000 up to $500,000 guaranteed)*		
SUPPLEMENTAL LIFE *(May require underwriting)*	◯ Employee Policy ____,000 *$20,000 to $500,000*	◯ Spouse Policy ____,000 *$20,000 to $200,000*	◯ Child(ren) Policy ____,000 *$5,000 or $10,000*

I, the undersigned, hereby make application on behalf of myself and listed legal dependent(s) for membership in the above elected insurance programs of Davis School District. I understand that if this application is accepted, my entitlement to the benefits of said programs will begin as determined by the enrollment requirements of the District. I represent and warrant that all information contained in this application for coverage is or will be true. I understand that if such information is untrue or become untrue in any material respect, I may be subject to disciplinary action, as well as loss of coverage for myself and my legal dependent(s).

Employee Signature ____________________ Date ____________

Employer Signature ____________________ Date ____________

SEND COMPLETED SIGNED FORM VIA EMAIL, FAX 801-402-5639 OR TO HUMAN RESOURCES OFFICE.

QUALIFIED LIFE STATUS CHANGE FORM

Terms and Conditions

TO ADD A DEPENDENT TO YOUR CURRENT COVERAGE

Marriage
To be covered, your new legal spouse must be added to your coverage within 30 calendar days of your date of marriage. The effective date of coverage will be retroactive to the date of marriage. Attach a copy of the marriage certificate to this form.

Birth
Your new child must be added within 30 calendar days of birth. The effective date of coverage will be retroactive to the date of birth.

Adoption
Your adopted child must be added to your coverage within 30 calendar days of adoption or placement for adoption. Coverage will be effective the date of adoption. The District Human Resources Benefits Office must verify the date of adoption by reviewing adoption documentation. For U.S. adoption, attach a copy of court signed adoption petition or adoption decree. For international adoption, attach a copy of visa or passport page that identifies the date of U.S. entry and a copy of adoption orders signed by a magistrate or other government official.

Legal Guardianship - National Qualified Child Medical Support Order
When you accept legal guardianship of a child, the child should be added to your coverage within 30 calendar days of the date the petition was signed by the court. A copy of the signed court order must be provided to the District Human Resources Benefits Office for review. Coverage becomes effective on the date the court order is effective, or on the date the child moves into your home, whichever is later.

Job Change or Termination with Loss of Benefits Eligibility—Spouse or Dependent Child
If your spouse or dependent child experiences an employment status change that results in loss of eligibility for coverage, your spouse or dependent child may be added to your coverage within 30 calendar days of the loss of coverage. You spouse or dependent child must meet established dependent eligibility criteria. Coverage will commence on the date in which the loss of benefits eligibility occurred. A Certificate of Coverage from the dependent's employer will be required.

TO DROP A DEPENDENT FROM YOUR CURRENT COVERAGE

Death of a Dependent
Provide the date of death of the dependent on this form.

Divorce/Legal Separation
Your spouse and applicable dependent child(ren) must be droped within 30 calendar days from your divorce or legal separation. Your spouse and applicable dependent will be the last day of the month in which your divorce or legal separation ws recorded with the Court. Attach a copy of the recorded divorce stamp found on the first/last page of your divorce or legal separation decree.

Loss of Dependent Status - Dependent Child
If your child marries and/or is no longer claimed as your dependent for federal IRS income tax reporting purposes and/or reaches the age of 26, the dependent child no longer meets the definition of an eligible dependent. Delete dependent within 30 calendar days of the loss of dependent status. Coverage will be cancelled on the last day of the month in which the dependent is no longer deemed an eligible dependent.

RETURN YOUR SIGNED AND COMPLETED FORM

BY FAX

Keep a copy of the fax transmission report with your form for verification purposes.

FAX to: 801-402-5639

BY MAIL

Make a copy for your records and send the original by **District Mail or U.S. Mail** to:

Davis School District
ATTN: Insurance Office
45 East State Street
P O Box 588
Farmington UT 84025-0588

DROP IT OFF IN PERSON

Make a copy for your records and hand deliver it to the Human Ressources/Insurance Office.

Davis School District Administration Building
8:00 a.m. – 4:30 p.m.
Insurance Office: 801-402-5200