

A. EMPLOYEE INFORMATION

LEGAL LAST NAME	FIRST NAME	MIDDLE NAME OR MI	SOCIAL SECURITY	DATE OF BIRTH (mm/dd/year)
/ /				
Change of Address? NO <input type="radio"/> YES <input type="radio"/>	ADDRESS	CITY	STATE	ZIP CODE
			GENDER <input type="radio"/> M <input type="radio"/> F	MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> 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: <input type="radio"/> Continue with my individual health plan. <input type="radio"/> Coordinate health plan with my spouse.			

B. QUALIFYING EVENT

<h4 style="margin: 0;">ADD COVERAGE</h4> <p style="font-size: small; margin: 0;">Based on the following event:</p> <input type="checkbox"/> New Born <input type="checkbox"/> Adoption (Attached Adoption Document) <input type="checkbox"/> Legal Marriage (Attached Marriage License or Certificate) <input type="checkbox"/> Legal Guardianship (Attached Dated Signed Court Order) <input type="checkbox"/> Loss of Other Coverage (Attached Certificate of Creditable Coverage) <input type="checkbox"/> Other _____	<h4 style="margin: 0;">DELETE COVERAGE</h4> <p style="font-size: small; margin: 0;">Based on the following event:</p> <input type="checkbox"/> Divorce or Legal Separation (Attached Divorce Decree or Legal Separation) <input type="checkbox"/> Death of Dependent <input type="checkbox"/> Marriage of Dependent <input type="checkbox"/> Dependent No Longer Eligible <input type="checkbox"/> Other _____ <small>*Spouse's signature is required if dropping him or her from coverage for reason other than divorce.</small> _____ <small>*Spouse Signature</small>	<h4 style="margin: 0;">DATE OF EVENT</h4> <p style="text-align: center; font-size: large; margin: 0;">/ /</p> <p style="text-align: center; font-size: large; margin: 0;">MM DD YEAR</p> <p style="font-size: small; margin: 5px 0;">This change form must be received by the Human Resources Office no later than thirty (30) calendar days of the qualifying event.</p>	<h4 style="margin: 0;">NAME CHANGE</h4> <p style="margin: 0;">FROM _____</p> <p style="margin: 0;">TO _____</p>
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C. DEPENDENT(S) INFORMATION

LIST DEPENDENTS TO WHOM THIS CHANGE APPLIES

ADD OR DELETE	RELATION	LEGAL NAME <small>FIRST, MIDDLE OR (MI), LAST NAME</small>	GENDER <small>M/F</small>	DATE OF BIRTH <small>MM/DD/YEAR</small>	SOCIAL SECURITY NUMBER
A <input type="radio"/> D <input type="radio"/>	Spouse				
A <input type="radio"/> D <input type="radio"/>	Child				
A <input type="radio"/> D <input type="radio"/>	Child				
A <input type="radio"/> D <input type="radio"/>	Child				
A <input type="radio"/> D <input type="radio"/>	Child				

D. REQUESTED ENROLLMENT CHANGE

HEALTH PLANS (Select One)	<input type="checkbox"/> Aetna Select Open Access <input type="checkbox"/> SHC SelectMed <input type="checkbox"/> Aetna Select Open Access High Deductible <input type="checkbox"/> SHC SelectMed High Deductible
DENTAL PLANS (Select One)	<input type="radio"/> Delta Dental Basic PPO <input type="radio"/> Delta Dental Premier Plus PPO
OPTICARE "120B" (Select One)	<input type="checkbox"/> Single Coverage <input type="checkbox"/> Two-Party Coverage <input type="checkbox"/> Family Coverage
BASIC LIFE INSURANCE	<input type="radio"/> Employee Policy <input type="radio"/> Spouse Policy <input type="radio"/> Child(ren) Policy
AD&D (Accidental Death & Dismemberment)	<input type="checkbox"/> Employee benefit only \$ _____ amount. <small>(Employee only benefit of \$10,000 up to \$500,000 guaranteed)</small>
SUPPLEMENTAL LIFE (May require underwriting)	<input type="radio"/> Employee Policy _____,000 <small>\$20,000 to \$500,000</small> <input type="radio"/> Spouse Policy _____,000 <small>\$20,000 to \$200,000</small> <input type="radio"/> Child(ren) Policy _____,000 <small>\$5,000 or \$10,000</small>

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 _____

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. Your 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 dropped 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 was 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

SCAN

Keep a copy of the email with your form for verification purposes.

SCAN - Insurance@dsdmail.net

BY MAIL

Make a copy for your records and send the original by **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 Resources/Insurance Office.

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