BENEFITS FAMILY STATUS CHANGE REQUEST

According to the **IRS Section 125 Plan (§1.125-4)** an individual may make changes to their insurance plan(s) as long as the request is made within ***thirty (30) days*** from the date of the dependent's qualifying event. A qualifying event is the date that your dependent's and/or spouse's insurance eligibility changes due to termination or commencement of insurance, or the date of marriage, death, birth, or adoption.

Changes can only be made to the insurance(s) affected by the qualifying event. **Please complete the attached Benefits Family Status Change Application and submit with one of the following documents within 30 days of the Qualifying Event.** The insurance carriers will not accept your status change request without supporting ***legal*** documentation:

- A letter from the previous carrier or employer stating ***date*** insurance will terminate, type of insurance (health, dental, etc) and dependents covered.
- A letter from the new carrier or employer stating ***date*** coverage will begin, type of insurance (health, dental, etc) and dependents to be covered.
- A copy of new group insurance card with ***date*** new coverage will begin, type of insurance (health, dental, etc) and dependents to be covered.
- A copy of the Medicare/Medicaid card, if spouse is eligible for Medicare/Medicaid.
- If adding a newborn, a copy of the footprints, ***including child's name and date of birth***. Or, if adopting, copy of adoption documentation.
- A copy of the death certificate for deceased dependent.
- A copy of marriage certificate, if married within the last thirty (30) days.
- A copy of divorce decree if dropping a spouse and/or dependent(s).
- If applying for new coverage due to a divorce, please provide a letter from the previous carrier stating ***date*** insurance will terminate.

You will return: Application and documentation as described above within 30 days of Qualifying Event. You may email, mail or fax the paperwork to the address/fax number shown on the application.

BENEFITS FAMILY STATUS CHANGE APPLICATION

Volusia County Schools ✶ Insurance & Employee Benefits Department
DeLand Administration Complex ✶ 200 N. Clara Avenue ✶ DeLand, FL 32720
Phone: (386) 734-7190 ✶ **Fax: (386) 943-3416**

Employee Name: _____

Social Security: _____-_____-_____ **Date of Birth:** _____

Mailing Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Worksite/Department: _____ **Job Title:** _____

QUALIFYING EVENT, DOCUMENTATION REQUIRED - (within 30 days of notification)

- ☐ Marriage (adding a spouse to existing plan only)
- ☐ Divorce (removing a spouse from existing plan only)
- ☐ Birth/Adoption
- ☐ Death
- ☐ Eligibility for Medicare/Medicaid
- ☐ Loss of coverage
- ☐ Gaining coverage
- ☐ Employment **or** Termination of Employment with ***Volusia County Schools***
- ☐ Spouse's Leave of Absence from Volusia County Schools

Office Use Only
Effective:
QE date:
Pay Type:
Health:
Dental:
Vision:

PLEASE INDICATE THE BENEFITS AFFECTED BY THIS STATUS CHANGE

- ☐ Health Insurance
- ☐ Dental Insurance
- ☐ Vision Insurance
- ☐ Daycare Flexible Spending Account (maximum amount you want on your card) $_____
- ☐ Medical Flexible Spending Account (maximum amount you want on your card) $_____

Changes to Dependent Information

Please indicate the dependents to be added/deleted to your insurance(s).

☐ Check here if you are enrolling in **Split Family** coverage and be sure to list your spouse and all children below.

Add/Delete	Relationship	M/F	Last Name	First Name	MI	Social Security	Date of Birth

- I represent that the statements on this application are true and complete to the best of my knowledge and belief. I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions.
- **I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

_____ _____
Signature Date