Qualifying Event Enrollment Form

Eligibility: **You have 31 days from the time of your Qualifying Event to complete this form.**

SECTION 1: Employee Information

Last Name:	First Name:	MI:	
Last 4 of Social Security #:	Date of Birth:	Sex: ☐ M ☐ F	
Mailing Address:	City:	State:	Zip
Cell Phone:	Email:		

SECTION 2: Qualifying Event

Special Enrollment Event Date: ___/___/_____ **Coverage Effective Date:** ___/___/_____

☐ **Newborn/Adoption** (Must Provide Copy of SS. Card) ☐ **Marital Status Change** (Must Provide Copy of Marriage/Divorce Certificate) ☐ **Loss of Eligibility** (Must Provide Cert. of Creditable Coverage) ☐ **Death** (Must Provide Copy of Death Certif.) ☐ **Gain Ins.** (Must Provide Proof of New Coverage)

☐ **Other** (Reason/Explanation) _____

_____

SECTION 3: Coverage Selection

☐ **Add Medical (MUST CIRCLE ONE)** BCBS HMO_____ BCBS PPO BCBS PPO
Primary Care Physician

☐ **FSA** _____
Monthly Amount

☐ **Add Dental** Low Option High Option

☐ **Add Vision**

SECTION 4: Dependent Information (Use additional page for additional dependents)

Spouse Name:	SP SSN:	SP DOB:
Child 1 Name:	Dep SSN:	Dep DOB:
Child 2 Name:	Dep SSN:	Dep DOB:
Child 3 Name:	Dep SSN:	Dep DOB:

SECTION 5: Declination Selection

☐ **Cancel Medical** ☐ **Cancel Dental** ☐ **Cancel Vision**

Employee Name:	☐ Reason: Other Coverage
Spouse Name:	☐ Reason: Other Coverage
Child 1 Name:	☐ Reason: Other Coverage
Child 2 Name:	☐ Reason: Other Coverage
Child 3 Name:	☐ Reason: Other Coverage

**If we don't receive required documentation within 31 days, you will have to wait until Open Enrollment to make changes to your plan(s).

Employee Signature: _____ **Date:** _____

09/09/2024