

QUALIFYING EVENT FORM

2025-2026 Plan Year



EMPLOYEE INFORMATION	Last Name		First Name	
	Email Address	Contact #		HEB ID#

QUALIFYING EVENT REASON: _____

DEPENDENT INFORMATION: Only if <u>ADDING</u> to your coverage			Date of Birth	SSN	Gender	Disabled?
SPOUSE	Last Name	First Name			<input type="checkbox"/> F <input type="checkbox"/> M	
CHILD	Last Name	First Name			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N
CHILD	Last Name	First Name			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N
CHILD	Last Name	First Name			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N
CHILD	Last Name	First Name			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Y <input type="checkbox"/> N

SELECT YOUR CHANGES	MEDICAL	DENTAL	VISION	HOSPITAL INDEMNITY	CRITICAL ILLNESS	VOLUNTARY LIFE
EMPLOYEE						
SPOUSE						
Child's Name						
Child's Name						
Child's Name						
Child's Name						

I understand that if I voluntarily drop coverage in the middle of the plan year for myself, my dependents, and/or spouse I will NOT be able to re-enroll until another qualifying event occurs. I understand I will need to provide the supporting documentation necessary to prove my status change to the benefits office within 30 days of the qualifying event date.

Initials _____

I understand I am automatically enrolled to participate in Section 125 for all benefits. I understand that if I elected to participate in the flexible spending plan any funds that have not been used by the end of the plan year **CANNOT** be returned to me. I must "use it or lose it." I understand that I cannot change any tax benefits before the next anniversary date except for a Change in Family Status. I further understand that my before-tax elections shall remain in effect from year to year until I cancel them. I understand that I may cancel my election participation only during the annual enrollment period unless I cancel my participation due to a change in family status.

Employee Signature: _____ Date: _____

*CONTINUE TO NEXT PAGE

ACTIVECARE PRIMARY (PCP REQUIRED)		
EMP		
EMP+SP		
EMP+CH		
FAM		
PCP#		

ACTIVECARE PRIMARY+ (PCP REQUIRED)		
EMP		
EMP+SP		
EMP+CH		
FAM		
PCP#		

ACTIVECARE HD - PPO		
EMP		
EMP+SP		
EMP+CH		
FAM		
NO PCP REQUIRED		

[Click HERE for Provider Search \(PCP\)](#)

CIGNA DENTAL PLANS								
PPO - HIGH PLAN			PPO - LOW PLAN			DENTAL HMO		
EMP			EMP			EMP		
EMP+1			EMP+1			EMP+1		
FAMILY			FAMILY			FAMILY		
NO PRIMARY DENTIST REQUIRED			NO PRIMARY DENTIST REQUIRED			CLINIC #-		

[Click HERE for dental provider search](#)

HOSPITAL INDEMNITY			
PLAN 1		PLAN 2	
EMP		EMP	
EMP+SP		EMP+SP	
EMP+CH		EMP+CH	
FAMILY		FAMILY	

CRITICAL ILLNESS				
	\$10,000	\$20,000	\$30,000	\$40,000
EMP				
EMP+CH				
EMP+SP				
FAMILY				

[Click here for rates](#)

VOLUNTARY LIFE INSURANCE		
EMPLOYEE	ADD \$	(Amount of Coverage) @ \$ (per paycheck)
SPOUSE	ADD \$	(Amount of Coverage) @ \$ (per paycheck)
CHILD(REN)	ADD \$10,000 per child @ \$0.60	(per paycheck)

SUPERIOR VISION	
EMP	
EMP+1	
FAMILY	

DISABILITY	
<input type="checkbox"/>	CANCEL my disability policy - (if you have an open claim, you cannot cancel your policy until open enrollment)

HEALTH SAVINGS ACCOUNT		
(only if enrolled for AC HD medical plan)		
MAX: \$179.16 (EMP Only) \$356.25 (FAM) - per paycheck		
DROP	ADD \$	per paycheck
CHANGE TO \$		per paycheck

FLEXIBLE SPENDING ACCOUNT (FSA & DCA)		
MAX: FSA \$112.50 Dependent Care \$208.33 (per paycheck)		
*FSA	ADD \$	CHANGE TO \$
DAY CARE	DROP	ADD \$
*You cannot drop if you have withdrawn more than your annual contribution.		

FOR BENEFITS OFFICE USE ONLY

Effective Date: _____

Entered in HUB Entered in E-Finance Credit Owed Additional Premiums Owed