



MIDYEAR BENEFIT CHANGE /QUALIFYING EVENT FORM

Employee's Full Name (please print) Employee Signature Employee ID # Date

*The IRS has very specific rules governing when you may change your benefit elections and the required documentation that you should submit when canceling or adding coverage. Employees have **60 calendar days** from the date of the qualifying event to enroll, cancel or make changes to their benefit elections. Documentation will need to be received and enrollment/change forms completed within this period. If you miss this deadline, you must wait until the next open enrollment to change your benefits.

CHECK WHAT PLAN YOU WANT TO CANCEL:

- MEDICAL DENTAL VISION

WHO DO YOU WANT TO REMOVE?

- EMPLOYEE SPOUSE CHILD(REN)

ADD A NEWBORN:

Name	Date of Birth	Gender	Social Security Number

***Usually, newborns are enrolled in employee's medical plan only. Please specify if you want to add dental/vision too.

IF ADDING, WHAT PLAN ARE YOU REQUESTING:

BCBS HIGH 157	HCH LOW 160	BCBS HMO 162	HCH HD 161
<input type="checkbox"/> Emp Only \$260 (Biweekly \$130)	<input type="checkbox"/> Emp Only \$130 (Biweekly \$65)	<input type="checkbox"/> Emp Only \$89 (Biweekly \$44.50)	<input type="checkbox"/> Emp Only \$40
<input type="checkbox"/> Emp & Spouse \$925 (Biweekly \$462.50)	<input type="checkbox"/> Emp & Spouse \$761 (Biweekly \$380.50)	<input type="checkbox"/> Emp & Spouse \$669 (Biweekly \$334.50)	<input type="checkbox"/> Emp & Spouse \$611 (Biweekly \$305.50)
<input type="checkbox"/> Emp & Child(ren) \$725 (Biweekly \$362.50)	<input type="checkbox"/> Emp & Child(ren) \$545 (Biweekly \$272.50)	<input type="checkbox"/> Emp & Child(ren) \$455 (Biweekly \$227.50)	<input type="checkbox"/> Emp & Child(ren) \$411 (Biweekly \$205.50)
<input type="checkbox"/> Family \$1,400 (Biweekly \$700)	<input type="checkbox"/> Family \$1,153 (Biweekly \$576.50)	<input type="checkbox"/> Family \$1,035 (Biweekly \$517.50)	<input type="checkbox"/> Family \$970 (Biweekly \$485)

Dental The Standard Low	Dental The Standard Mid	Dental The Standard High	VSP Vision
<input type="checkbox"/> Emp Only \$30.68 (Biweekly \$15.34)	<input type="checkbox"/> Emp Only \$37.12 (Biweekly \$18.56)	<input type="checkbox"/> Emp Only \$56.32 (Biweekly \$28.16)	<input type="checkbox"/> Emp Only \$7.12 (Biweekly \$3.56)
<input type="checkbox"/> Emp & Spouse \$61.88 (Biweekly \$30.94)	<input type="checkbox"/> Emp & Spouse \$74.16 (Biweekly \$37.08)	<input type="checkbox"/> Emp & Spouse \$125.12 (Biweekly \$62.56)	<input type="checkbox"/> Emp & Spouse \$12.82 (Biweekly \$6.41)

<input type="checkbox"/> Emp & Child(ren) \$51.88 (Biweekly \$25.94)	<input type="checkbox"/> Emp & Child(ren) \$100.08 (Biweekly \$50.04)	<input type="checkbox"/> Emp & Child(ren) \$113.52 (Biweekly \$56.76)	<input type="checkbox"/> Emp & Child(ren) \$13.58 (Biweekly \$6.79)
<input type="checkbox"/> Family \$79.56 (Biweekly \$39.78)	<input type="checkbox"/> Family \$137.16 (Biweekly \$68.58)	<input type="checkbox"/> Family \$161.48 (Biweekly \$80.74)	<input type="checkbox"/> Family \$20.34 (Biweekly \$10.17)

_____	_____	_____
Names of Spouse/Dependent to be covered	Date of birth & Gender	Social Security
_____	_____	_____
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_____	_____	_____
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Step 2 Select the Qualifying Event and attach the required documentation

<input type="checkbox"/> Birth	Birth certificate or copy of hospital's birth facts
<input type="checkbox"/> Placement of child for adoption	Adoption or legal papers indicating placement for adoption
<input type="checkbox"/> Becoming the legal guardian	Court Order
<input type="checkbox"/> Marriage	Marriage certificate stating date of marriage
<input type="checkbox"/> Divorce	Divorce decree with applicable sections
<input type="checkbox"/> Death of spouse or child	Copy of Death Certificate
<input type="checkbox"/> Loss/Gain of group health care coverage	Letter from HR/Benefits Dept.; insurance; or COBRA paperwork with date insurance ends/begins; name of individuals affected by this change and effective dates of loss or gain of coverage
<input type="checkbox"/> A significant cost change in premium (15% or more) under your, your spouse's, or your dependent's plan.	Letter from Human Resources explaining circumstances
<input type="checkbox"/> Entitlement or loss of Medicare, Medicaid or CHIP	Copy of your Medicare card or Medicare/Medicaid/CHIP letter
<input type="checkbox"/> Beginning or returning from an unpaid leave (FMLA)	Documented Internally
<input type="checkbox"/> Dependent Care – change in cost	Permitted in summer months

Step 3 Date of Event & Date of Benefit Change

Calendar date the above status occurred: _____ Effective date: _____ (the first of the month following the event date)

*Payroll changes will be effective on the first pay period following approval. If your event is due to the birth of a child, your effective date will be retroactive to the date of birth even though your new deduction amount will not go into effect until the first pay period following approval.

Notes:

(Benefits Use Only) Accepted by: _____ Date: _____