

Employee Information

Full Name:		Employee ID (EID):	
Email:		Campus / Location:	

Qualifying Life Event Details

Type of Qualifying Event

- | | |
|---|--|
| ☐ Marriage | ☐ Divorce / Legal Separation |
| ☐ Birth of Child | ☐ Adoption / Placement for Adoption |
| ☐ Loss of Other Coverage | ☐ Gain of Other Coverage |
| ☐ Death of Dependent | ☐ Change in Employment Status |
| ☐ Other <input type="text"/> | |

Qualifying Life Event Date:

QLE Description:

Dependent Information

Dependent Name	Relationship	Date of Birth	Sex	SSN (Full)	PCP and PCP ID#

Medical

Active Care HD

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Active Care Primary

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Active Care Primary Plus

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Dental

Cigna DHMO

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Ameritas PPO ☐ High ☐ Low

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Other Benefits

Vision ☐ High ☐ Low

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Long-Term Disability (LTD)

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only

Life Insurance ☐ Permanent ☐ Term

Action: ☐ Add ☐ Remove ☐ Change Policy Amount Requested:

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Health Savings Account (HSA) **compatible with Active Care HD plan only*

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Family

Monthly Deduction Amount Requested:

Flexible Spending Account (FSA)

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Family

Monthly Deduction Amount Requested:

Critical Illness

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Cancer Insurance

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Accident Insurance ☐ High ☐ Low

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Other Benefits (continued)

Hospital Indemnity ☐ High ☐ Low

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Documentation

Supporting documents attached: ☐ Yes ☐ No

(Examples: marriage certificate, birth certificate, loss of coverage letter, etc.)

Employee Certification

I certify that the information provided is accurate and that this request is due to a qualifying life event. I understand that changes must be consistent with the event and submitted within the required timeframe. I acknowledge and agree to the applicable premiums as outlined in the Benefits Guide and/or benefits website. I understand that effective dates will be determined based on plan rules.

Employee Signature:

Date:

Benefits Dept Use Only

Date Received: ☐ Approved: Yes ☐ No

Processed By: