 **QUALIFYING EVENT FORM**

**We must receive this form and your Enrollment/Change form(s)**

**within 31 calendar days of the event.**

IRS rules dictate that employees enrolled in the medical, dental, vision, and flexible spending accounts cannot enroll in or change enrollment options during the plan year except during an open enrollment period, or in the event of a “change in status” life event. Employees are encouraged to provide documentation prior to 31 days and, except as noted below, under no circumstance will a change be permitted to the employee’s benefits during the plan year beyond 31 days of the life event.

**Employee Name (please print):** **Effective Date:**

**Employee #:                                Date of Qualifying Event:**

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| **Changes for these events are effective the date of event:**  Birth, Adoption or Placement for Adoption – *Provide documentation of birth date or copy of the adoption agreement or pre-*  *adoptive placement agreement.* |

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| **Removal of ineligible dependents is effective at the end of the month in which dependents become ineligible:**  Divorce – Copy of final divorce decree must be attached.  Provide address of former spouse:    Child no longer eligible dependent : date of 26th birthday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provide child’s address, if different:    Death – Provide documentation of date of death. |

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| **Other changes are effective the first of the month following receipt of your request or following the event, whichever is later:**  Marriage – *Copy of marriage certificate must be attached.*  Custody or guardianship – *Attach copy of custody orde*r.  Change in eligibility for Medicare, Medicaid or other government sponsored health care \*  **Your enrollment/change request must be submitted within 60 days for loss or gain of this coverage.**  Change of dependent’s employment status \*  Benefit Eligibility Change Date:  Significant change in dependent’s employer provided coverage \*  (*NOTE: This event is not a qualifying event for Health Care Flexible Spending Account changes.)*  Dependent’s employer has a different Open Enrollment period and Plan Year\*  Date of coverage change on Spouse’s employer-provided plan:  *(NOTE: This event is not a qualifying event for Health Care Flexible Spending Account changes.)*  Loss of coverage due to:    \* See page 2 for documentation needed for each event |

**Important – Read carefully before signing**

This is to certify that I incurred the family status change checked above, and therefore, wish to change my plan benefits as indicated on the enrollment/change form(s) attached. I understand that the change requested must be consistent with the family status change event and the effective date of the change to the coverage will be as indicated above. I further understand that documentation of status change must be received by the Human Resources department no later than 31 days from the date of the life event or no later than 60 days if due to loss or gain of government coverage. I elect to participate in the Benefits Plan and I authorize the Court to reduce my compensation by the amount required to pay my share of the premiums for the coverage that I have elected.

**Employee Signature: Date:**

**Qualifying Events**

**Additional Documentation**

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| **Qualifying Event** | **Documentation Needed** |
| **Change in eligibility for Medicare, Medicaid or other government sponsored health care** | HIPAA Certificate from former plan  **OR**  Letter on prior employer’s/government entities letterhead stating:  • Date letter is prepared  • Name of employer/government entity that provided coverage  • Name of employee/dependents losing coverage  • Date coverage ends  • Name of prior carrier |
| **Change of dependent’s** **employment status** | HIPAA Certificate from former plan  **OR**  Letter on employer’s letterhead stating:  • Date letter is prepared  • Name of employee and covered dependents  • Name of employer providing coverage  • Date coverage ended (if adding spouse/dependents to Court coverage)  OR  Date coverage will begin (if dropping spouse/dependents from Court coverage)  • Name of carrier  • Employer contact name, phone number, address |
| **Significant change in dependent’s** **employer-provided coverage** | Letter on spouse’s employer’s letterhead stating:  • Date prepared  • Name of employer providing coverage  • Name of employee and covered dependents  • Name of current carrier  • Description of significant change in coverage  • Effective date of significant change in coverage  • Employer contact name, phone number, address |
| **Dependent’s** **Employer’s Open Enrollment and Benefits Plan Year is different from the Court’s** | Letter on spouse’s employer’s letterhead stating:  • Date letter is prepared  • Name of Spouse’s employer  • Name of Spouse/dependents changing coverage  • Date coverage change is effective  • Employer contact name, phone number, address |
| **Loss of coverage** | HIPAA Certificate from former plan  **OR**  Letter on prior employer’s letterhead stating:  • Date letter is prepared  • Name of employer that provided coverage  • Name of employee/dependents losing coverage  • Date coverage ends  • Name of prior carrier  • Employer contact name, phone number, address |