

EMPLOYEE STATEMENT OF QUALIFYING EVENT

Instructions

- Locate your qualifying change in event & complete entire applicable section
- Pay close attention to the "SC" Code located in the right hand column
- Complete the Employee Certification Box with your signature & date
- Attach to your *Personal Benefit Election Change Request Form*

QUALIFYING EVENTS

- 1. Marriage** SC 1.1.1
I was married as of (date) _____
Spouse Name: _____ SSN _____
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- 2. Lost Spouse** SC 1.1.2
I lost a spouse as of (date) _____
Reason: Divorce Legal Separation Annulment Death of Spouse
Spouse Name: _____ SSN _____
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- 3. Gained Dependent** SC 1.2.1
I have gained the dependent(s) listed below as of (date) _____
Dependent Name(s): _____
Reason: Birth Adoption Legal Guardianship
-
- 4. Lost Dependent** SC 1.2.2
I have lost the dependent(s) listed below as of (date) _____
Dependent Name(s): _____
Reason: Death Placement for Adoption
-
- 5. Employee Gained Eligibility Through Change In Employment** SC 1.3.1, SC 1.3.3
I have gained eligibility under the Plan through a change in employment as of (date): _____
Change: Part-Time to Full-Time Hourly to Salary Back from Strike/Lockout
 Rehired after 30 days of termination Return from Unpaid Leave after 30 days
 Other event: (describe): _____
Newly Eligible Benefits: All under Plan Specific Component(s) _____

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____

6. Spouse/Dependent Gained Eligibility through Change in Employment SC 1.3.5
My spouse or dependent has gained eligibility under their employer's Plan through a change in employment as of (date): _____
Newly Eligible Benefit(s): All under Plan Specific Component(s) _____
Benefits Elected as a result: _____ as of (date) _____
Name of Spouse Dependent _____
Change: _____ Hired Part-Time to Full-Time Hourly to Salary Back from Strike/Lockout
 Other event: (describe): _____

7. Spouse/Dependent Lost Eligibility through Change in Employment SC 1.3.6
My spouse or dependent has lost eligibility under their employer's Plan through a change in employment as of (date) _____
Lost Benefit(s): All under Plan Specific Component(s) _____
Benefits Dropped as a result: _____ as of (date) _____
Name of Spouse Dependent _____
Change: Terminated Full-Time to Part-Time Salary to Hourly Go on Strike/Lockout
 Other event: (describe): _____

8. Dependent Gains Eligibility under Employee's Plan SC 1.4.1
My dependent has become eligible for my plan or one of its components as of (date) _____
Dependent Name: _____
Newly Eligible Benefit(s): All under Plan Specific Component(s) _____
Reason for Eligibility: Attains Specified Age Becomes Single Becomes Student
 Other event: (describe): _____

9. Dependent Loses Eligibility under Employee's Plan SC 1.4.2
My dependent is no longer eligible for my Plan or one of its components effective as of (date) _____
Dependent Name: _____
Lost Benefit(s): All under Plan Specific Component(s) _____
Reason for Ineligibility: Attains Specified Age Gets Married Ceases to be a student
 Other event: (describe): _____

10. Employee Gained Eligibility for Plan Component through Change of Residence SC 1.5.1
A change in my residence has made me eligible one of Plan's components effective as of (date) _____
New Address: _____
Newly Eligible Component(s): _____

11. Employee Lost Eligibility for Plan Component through Change of Residence SC 1.5.2
A change in my residence has made me ineligible for one Plan's components effective _____
New Address: _____
Newly Ineligible Component: _____

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____

12. Spouse/Dependent Gained Eligibility for Plan Component through Change of Residence SC 1.5.3
A change in my spouse's or dependent's residence has made them eligible for one of the components of my Plan effective as of (date) _____
New Address: _____
 Spouse Dependent Name: _____
Newly Eligible Component(s): _____
Election Resulting from Change: _____

13. Spouse/Dependent Lost Eligibility for Plan Component through Change of Residence SC 1.5.4
A change in my spouse's or dependent's residence has made them ineligible for one of the components of my Plan effective as of (date) _____
New Address: _____
 Spouse Dependent Name: _____
Component(s) Dropped as a Result: _____

14. Day Care Provider Changed Rates SC 2.1.3
The Day Care Provider for my child has changed rates as of (date): _____
Dependent Name: _____
Name of Day Care Provider: _____
Day Care Provider is my relative is not my relative.
Old Rates: _____ New Rates: _____

15. Individually Owned Policy Changed Rates SC 2.1.3
My Individually Owned Policy has changed rates as of (date): _____
Policy Carrier Name: _____
Policy Number: _____ Policy Type: _____
Old Rates: _____ New Rates: _____

16. Employee Response to Significant Cost Increase SC 3.1.1b
I understand my elected benefit _____
has had a significant cost increase.
 I understand that _____
has been categorized as a similar coverage, and I would like to replace my current election with it.
 I understand that there is no similar coverage, so I would like to drop my current election.

17. Employee Response to Significant Coverage Curtailment SC 4.1.1b
I understand the coverage under my elected benefit _____
has been significantly curtailed.
 I understand that _____
has been categorized as a similar coverage, and I would like to replace my current election with it.
 I understand that there is no similar coverage, so I would like to drop my current election.

18. Employee Response to New Benefit or Option Offered under Plan SC 5.1.1b
I understand that a new benefit or option has been offered under the Plan.
 I choose to elect the new benefit or option: _____
 I would like to replace my current election _____
with the new benefit or option: _____

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____

19. Employee Response to Dropping of Benefit or Option Offered under Plan SC 5.1.2b
I understand that a benefit or option I have elected under the Plan has been dropped.
 I would like to replace the dropped benefit or option _____
with _____

20. Employee Response to Benefit or Option Being Replaced under Plan SC 5.1.3b
I understand that _____
has been replaced with _____
and it is considered to have a significant cost increase significant coverage curtailment.
 I understand that _____
has been categorized as a similar coverage, and I would like to replace my current election with it.
 I understand that there is no similar coverage, and I would like to drop my current election.

21. New Day Care Provider for Employee's Dependent SC 5.1.4
I have changed Day Care Providers for my child as of (date): _____
Previous Day Care Provider: _____
New Day Care Provider: _____
Old Rates: _____ New Rates: _____

22. Spouse/Dependent's Employer Has Increased Coverage SC 6.1.1
My spouse's or dependent's employer has increased coverage effective as of (date) _____
 Spouse Dependent Name: _____
Newly Eligible Benefit(s): _____
Benefits Elected as a Result: _____
_____ effective as of (date) _____

23. Spouse/Dependent's Employer Has Dropped Coverage SC 6.1.2
My spouse's or dependent's employer has dropped coverage effective _____
 Spouse Dependent Name: _____
Benefits Dropped as a Result: _____
_____ Effective as of (date) _____

24. Spouse Changed Elections During Open Enrollment for Her Employer's Plan SC 6.1.3
My spouse changed elections during their open enrollment. Elections effective as of (date): _____
Coverages Dropped: _____
Coverages Elected: _____

25. Beginning FMLA Leave SC 7.1.1
I am going on FMLA effective _____
Remember to complete the **Benefit Payment Options while on FMLA** form.

26. Returning from FMLA Leave SC 7.2.1
I am returning from FMLA effective _____
This notification only needs to be submitted if the employee revoked elections during the FMLA and wishes to reinstate the elections.

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____

- 27. COBRA** SC 8.1.1
 I have experienced a COBRA event in relation to my employer, and I remain an eligible participant in this Cafeteria Plan.
 COBRA Event: _____
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- 28. COBRA** SC 8.1.2
 My spouse/dependent has experienced a COBRA event in relation to their employer, and they remain an eligible participant in this Cafeteria Plan.
 Name of Spouse Dependent: _____
 COBRA Event: _____
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- 29. Judgment, Decree, or Order Requiring Employee to Provide Coverage for Dependent** SC 9.1.1
 I have a Judgment, Decree, or Order requiring me to provide Coverage under my Plan for my Dependent(s) effective as of (date) _____,
 Name of Dependent(s): _____
 Coverage Required: _____
-
- 30. Judgment, Decree, or Order Requiring Another Person to Provide Coverage for Dependent** SC 9.1.2
 I have a Judgment, Decree, or Order requiring someone else to provide coverage for my Dependent(s) effective as of (date) _____.
 Name of Dependent(s): _____
 Coverage Required: _____
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- 31. Employee Attained Eligibility for Medicare, Medicaid, or other Federal/State Benefit** SC 10.1.1
 I have become eligible for Medicare Medicaid other Federal/State Agency Benefits
 (other than coverage for pediatric vaccines) effective as of (date) _____.

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- 32. Spouse/Dependent Attained Eligibility for Medicare, Medicaid, or other Federal/State Benefit** SC 10.1.2
 My spouse or dependent(s) has become eligible for Medicare Medicaid other Federal/State Agency Benefits (other than coverage for pediatric vaccines) effective as of (date) _____
 Spouse Dependent Name: _____
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- 33. Employee Lost Eligibility for Medicare, Medicaid, or other Federal/State Benefit** SC 10.2.1
 I have lost my eligibility for Medicare Medicaid other Federal/State Agency Benefits (other than coverage for pediatric vaccines) effective as of (date) _____.
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- 34. Spouse/Dependent Lost Eligibility for Medicare, Medicaid, or other Federal/State Benefit** SC 10.2.2
 My spouse or dependent(s) has lost their eligibility for Medicare Medicaid other Federal/State Agency Benefits (other than coverage for pediatric vaccines) effective as of (date) _____.
 Spouse Dependent Name: _____

Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: _____ Date: _____

Employer: _____