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 _____

☐ **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 _____

☐ **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

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 non-FMLA 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 under their Employer's Plan 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 under their Employer's Plan 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. Employee moves out of HMO Service Area** SC 1.5.3

I moved out of my HMO Service Area as of (date)_____ .

☐ **13. Spouse/Dependent Gained 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 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: _____

☐ **14. Spouse/Dependent Lost Eligibility for Plan Component through Change of Residence** SC 1.5.5

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: _____

☐ **15. 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:_____

☐ **16. 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:_____

☐ **17. 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.

☐ **18. Employee Response to Significant Cost Decrease** SC 3.2.1b

I understand that the (benefit) _____

has had a significant cost decrease.

☐ I would like to replace my current election of (benefit) _____ and elect the above benefit.

☐ I would like to add the above benefit.

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 Significant Coverage Curtailment (without loss of coverage)** SC 4.1.1b

I understand the coverage under my elected benefit _____
has been significantly curtailed, but is not considered to be a loss of coverage.

☐ I understand that _____ has been categorized as a similar coverage, and I would like to replace my current election with it..

☐ **20. Employee Response to Significant Coverage Curtailment that is considered a loss of coverage** SC 4.1.1c

I understand the coverage under my elected benefit _____ has been significantly curtailed and is considered to be a loss of coverage

☐ 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.

☐ **21. New Day Care Provider for Employee's Dependent** SC 5.1.5

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. Day Care Provider for Employee's Dependent has changed rates.** SC 5.1.6

The Day Care Provider has changed rates effective (date): _____
The Day Care Provider is not a relative.
Old Rates_____ New Rates:_____

☐ **23. Coverage has been Increased Under Another Employer Plan** SC 6.1.1

Coverage under (plan) _____
For (type of benefit)_____
Has been increased for ☐ myself, ☐ my spouse and/for ☐ my dependent(s) effective as of (date)_____
Dependent Names: (if applicable)_____

☐ **24. Coverage has been Decreased Under Another Employer Plan** SC 6.1.2

Coverage under (plan)_____
For (type of benefit) _____
Has been decreased for ☐ myself, ☐ spouse and/for ☐ dependent(s) effective as of (date)_____
Dependent Names: (if applicable) _____

☐ **25. Eligibility for Coverage has been Gained Under Another Employer Plan** SC 6.1.1

Eligibility has been gained (and benefit elected) under (plan) _____
For (type of benefit) _____
Coverage under that benefit will start for ☐ myself, ☐ my spouse and/for ☐ my dependent(s) effective (date) _____
Dependent Names: (if applicable)_____

☐ **26. Eligibility for Coverage has been Lost Under Another Employer Plan** SC 6.1.2

Eligibility has been lost (and benefit dropped) under (plan) _____
For (type of benefit):_____
Coverage under that benefit will stop for ☐ myself, ☐ my spouse and/for ☐ my dependent(s) effective (date)_____
Dependent Names: (If applicable)_____

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. Spouse or Dependent Dropped/Decreased Elections under Their Cafeteria Plan during Open Enrollment** SC 6.1.3

My ☐ spouse ☐ dependent changed elections under their cafeteria plan during open enrollment effective (date) _____ .

The following benefits were dropped or decreased:

Benefit:_____ _____ ☐ Dropped ☐ Decreased

Benefit:_____ _____ ☐ Dropped ☐ Decreased

Benefit:_____ _____ ☐ Dropped ☐ Decreased

☐ **28. Spouse or Dependent Added/Increased Elections under Their Cafeteria Plan during Open Enrollment** SC 6.1.3

My ☐ spouse ☐ dependent changed elections under their cafeteria plan during open enrollment effective (date) _____ .

The following benefits were dropped or decreased:

Benefit:_____ _____ ☐ Added ☐ Increased

Benefit:_____ _____ ☐ Added ☐ Increased

Benefit:_____ _____ ☐ Added ☐ Increased

☐ **29. Employee Lost Coverage under Group Health Plan of a Governmental or Educational Institution** SC 6.1.4

I lost coverage under (Plan)_____ effective as of (date)_____

☐ Spouse ☐ Dependent Name _____

☐ **30. Spouse/Dependent Lost Coverage under Group Health Plan of a Governmental or Educational Institution** SC 6.1.4

My spouse/dependent lost coverage under (Plan)_____ effective as of (date)_____

Remember to complete the ***Benefit Payment Options while on FMLA*** form.

☐ **31. Beginning FMLA Leave** SC 7.1.1

I am going on FMLA effective _____

Remember to complete the ***Benefit Payment Options while on FMLA*** form.

☐ **32. 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.

☐ **33. COBRA** SC 8.1.1

I have experienced a COBRA event for a benefit elected under Cafeteria Plan, and I remain an eligible participant in this Cafeteria Plan..

COBRA Event: _____ Effective as of (date):_____

Benefit:_____

☐ **34. COBRA** SC 8.1.2

My spouse/dependent has experienced a COBRA event for a benefit I have elected under my cafeteria plan.

Name of ☐ Spouse ☐ Dependent: _____

COBRA Event: _____

Benefit:_____

☐ **35. Judgment, Decree, or Order Requiring Employee to Provide Coverage for Dependent** SC 9.1.2

I have a Judgment, Decree, or Order requiring someone to provide coverage for my Dependent(s) .

Name of Dependent(s): _____

Coverage Required:_____

Coverage was provided as of (date):_____

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: _____

☐ **36. 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 Re uired: _____

Coverage Effective as of (date):_____

☐ **37. Employee Attained Eligibility for Medicare or Medicaid** SC 10.1.1

I have become eligible for ☐ Medicare ☐ Medicaid (other than coverage for pediatric vaccines).

My coverage is effective as of (date) _____.

☐ **38. Spouse/Dependent Attained Eligibility for Medicare or Medicaid** SC 10.1.2

My spouse or dependent(s) has become eligible for ☐ Medicare and ☐ Medicare (other than coverage for pediatric vaccines).

The coverage is effective as of (date) _____

☐ Spouse ☐ Dependent Name: _____

☐ **39. Employee Lost Eligibility for Medicare or Medicaid** SC 10.2.1

I have lost my eligibility for ☐ Medicare and ☐ Medicare (other than coverage for pediatric vaccines) effective as of (date) _____.

☐ **40. Spouse/Dependent Lost Eligibility for Medicare or Medicaid** SC 10.2.2

My spouse or dependent(s) has lost their eligibility for ☐ Medicare and ☐ Medicare (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: _____