QUALIFYING LIFE EVENT AND BENEFIT CHANGE FORM



EMPLOYER:				DATE	E OF	CHANG	GE:				
LOCATION:			T								
TYPE OF CHANGE	□ NAME □ ADDRES	SS □ QLE	□P	HON	Ε□E	EMAIL	□ BENEFI	CIARY			
EMPLOYEE LAST NAME	FIRST NAME		MI	DOB	(mm/	dd/yy)	SOCIAL S	ECURITY	NUMBER		
EMPLOYEE MAILING ADDRESS	STREET			APT#	ŧ	CITY		STATE	ZIP CODE		
EMAIL ADDRESS			PHC	NE				GENGER			
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Events consistent with adding fam	ily members to coverag	e:			er eve		_				
Marriage (certified marriage certificate) Birth or Adoption (birth certificate/hospital announcement or adoption agreement)					Employment Change: Full-time to Part-time						
Judgment, Decree, or Order to Add Child (court order)				☐ Part-time to Full-time ☐ Unpaid Leave Began							
Lost eligibility Under Governmental Plan (government documentation)				Unpaid Leave Ended							
Lost eligibility Under Medicare or Medicaid (government documentation) Spouse or Child Lost Eligibility Under Their Employers Plan (employer documentation)					Dependent Care Cost or Coverage Change (documentation from dependent care provider)						
Spouse or Child Lost Eligibility Under Their E	mpioyers Pian (empioyer docum	entation)						ss of Other Cov	erage (HIPAA		
Events consistent with removing fa	amily members from co	verage:		ce	rtificate)			3		
Divorce (divorce decree)				Move Affecting Eligibility for Health Care Plan (agency validates							
Death of Spouse (documentation validating death)					move) Other Employers Open Enrollment or Plan Change (employer						
☐ Death of Child (documentation validating death) ☐ Child Covered Under Plan Lost Eligibility (documentation to support)					cument		on Emountone o	Trial orlango (ompioyor		
Judgment, Decree or Order to Remove Child (court order)								ge Health Plan			
Gained Eligibility Under Medicare or Medicaid (government documentation)					n of the te of co		ice coverage en	rollment and the	e effective		
Spouse or Child Gained Eligibility Under Thei	r Employers Plan (employer docu	umentation)		ua	16 01 00	verage)					
ADD COVERAGE FOR: TERMINATE COVERAGE FOR:	□ SPOUSE □ CHILE										
DEPENDENTS:											
LAST NAME	FIRST NAME	SEX		DOB	(mm/do	d/yy)	SOCIAL S	SECURITY	NUMBER		
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