2012 Qualifying Status Change ("Life Event") Form

Employee Name: _____
Last First Middle

Social Security Number/UM "C" Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email Address: _____

Qualifying Status Change Events
(check and date all that apply)

Event	Date	Event	Date
❑ Marriage	_____	❑ Divorce	_____
❑ Death ❑ Spouse ❑ Dependent	_____	❑ Change in Dependent Care Provider	_____
❑ Birth of Child	_____	❑ Adoption (or placement for) adoption of child	_____
❑ Ineligibility of dependent (due to age or access to insurance through employer)	_____	❑ Employee's Unpaid Leave ❑ Begins ❑ Ends	_____
❑ Spouse has obtained other coverage	_____	❑ Spouse's Unpaid Leave ❑ Begins ❑ Ends	_____
❑ Spouse Employment ❑ Begins ❑ Ends	_____	❑ Other _____ _____ _____	_____

Type of Change Requested

Change Existing Account	Start Account	Terminate Account
❑ Medical ❑ Dental ❑ Flexible Spending	❑ Medical ❑ Dental ❑ Flexible Spending	❑ Medical ❑ Dental ❑ Flexible Spending

I certify that on the date(s) indicated, I incurred the Qualifying Change in Status event(s) checked above and therefore wish to change my plan elections as indicated. I understand that the change requested must be consistent with the Change in Status event and can only apply to the remaining portion of my coverage period.

Employee Signature: _____ Date: _____

You must submit this completed form, along with evidence supporting a Qualifying Change in Status to Benefits Administration within 30 days of the event.

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Coral Gables Campus

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