Qualifying Event Change Form

You have 30 days from the date of your Qualifying Event to submit this form with supporting documentation and enrollment forms (if required) to Benefits@centricconsulting.com

Today's Date:_____
Employee Name:_____
Dependent's Name:_____ Male/Female ___ DOB_____
Dependent's Social Security Number:_____ Relationship:_____
Dependent's Name:_____ Male/Female ___ DOB_____
Dependent's Social Security Number:_____ Relationship:_____
(Please attach additional sheets if necessary)

Section 1: Qualified Changes- Check all that apply:

____ Marriage/Domestic Partnership
____ Divorce
____ Birth or Placement for Adoption
____ Change of my employment status (PT to FT or FT to PT)
____ Change of a spouse's employment status (hired, term, full-time to part-time or part-time to full-time)
____ Death of a spouse or dependent
____ Dependent no longer meets eligibility status
____ Other: _____

Section II: Date of Qualifying Event: _____

Section III: Benefit Plan Change – Please include the enrollment form if provided. The benefit(s) I wish to change is (are):

____ Medical Plan H1 HSA Medical ____ H2 HSA Medical ____ P1 PPO____
Change From: ____Employee ____EE/Spouse/DP ____EE/Child(ren) ____Family ____None
Change To: ____Employee ____EE/Spouse/DP ____EE/Child(ren) ____Family ____None

____ Dental Blue 100/200/300
Change From: ____Employee ____EE/Spouse/DP ____EE/Child(ren) ____Family ____None
Change To: ____Employee ____EE/Spouse/DP ____EE/Child(ren) ____Family ____None

____ Vision
Change From: ____Employee ____EE/Spouse/DP ____EE/Child(ren) ____Family ____None
Change To: ____Employee ____EE/Spouse/DP ____EE/Child(ren) ____Family ____None

____ HSA (if electing or making changes to H1/H2 HSA Medical). Amount electing per pay period $____

____ FSA (if electing or making changes to H3 PPO). Amount electing Per Pay Period $____

Section IV: The supporting documentation I have included is: _____

Please Read Carefully Before Signing This Form:
I have indicated changes to my benefit elections and I understand that these changes will remain in effect until the next annual election period unless there is a change in my family status as defined by the Plan. I authorize Aureon HR to reduce my earnings by the amount of these elections or take deductions for the after tax elections. I authorize the company to keep these elections in effect for any subsequent years unless I provide specific written notification in accordance with plan enrollment provisions.

Printed Name_____

Signature: _____ Date: _____

Supporting Documentation

Marriage/DP:

To Add Spouse:

- Marriage Certificate
- Domestic Partner Affidavit
-

To Drop Coverage:

- Letter from spouse's employer indicating:
    1. Type of coverage
    2. Persons affected
    3. Effective date of coverage

Divorce:

To Add Coverage:

Copy of section of Divorce Decree indicating names and date of Final Judgment

OR

Letter from attorney indicating names of parties and date of Final Judgment

AND

Letter from former spouse's employer indicating coverage types and coverage end date

To Drop Coverage: (COBRA Notification Form will be sent to former spouse)

Copy of section of Divorce Decree indicating names and date of Final Judgment

OR

Letter from attorney indicating names of parties and date of Final Judgment

Birth/Adoption:

One of the following:

Doctor's Letter
Hospital Letter
Birth Certificate
Placement Agreement

Change of Employment Status of Your Spouse:

Letter from spouse's employer indicating:

Type of change (new hire, term, change in hours)
Date of Event (date of hire or term)
Type of coverage effective (medical, dental, vision etc.)
Effective date of coverage change
Persons affected

Death of Spouse or Dependent:

Copy of Death Certificate