QUALIFIED LIFE STATUS CHANGE FORM

FAX: 385-646-4319

FOR INTERNAL USE ONLY

Effective Date of Change: COB HRC BM DEP COM PD RECALC DUAL COVERAGE: YES OR NO

EMPLOYEE INFORMATION

GRANITE ID NUMBER	LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP CODE	☐ Male ☐ Female

TELEPHONE NUMBER	EMAIL ADDRESS	DATE OF BIRTH	☐SINGLE ☐MARRIED ☐DIVORCED ☐ WIDOWED MARITAL STATUS

WORK LOCATION	SUPERVISOR	POSITION	☐Teacher ☐Classified ☐Secretary ☐Administrator EMPLOYMENT CLASSIFICATION	FTE STATUS

QUALIFYING LIFE STATUS CHANGE EVENT

EVENT DATE

_____

This form must be received by the DISTRICT HR BENEFITS OFFICE within **30 calendar days** after the qualified event occurred

ADD

- ☐ Birth/Adoption (Copy of Adoption Documentation Required)
- ☐ Legal Marriage (Copy of Marriage Certificate Required)
- ☐ Legal Guardianship (Copy of Signed/Dated Court Order Required
- ☐ Loss of Other Coverage (Copy of Letter Certifying Other Coverage was Lost)
- ☐ Granite FTE Status Change

(From _____% to _____%)

DROP

- ☐ Divorce/Legal Separation (Copy of signed/dated court order or decree)
- ☐ Death of Dependent
- ☐ Marriage of Dependent
- ☐ Age Maximum Reached (26)
- ☐ Dependent Gains Other Eligibility (Copy of Coverage Letter)
- ☐ Granite FTE Status Change

(From _____% to _____%)

AFFECTED MEMBERS

LIST ONLY THOSE TO WHOM THE CHANGE APPLIES . . . .

ACTION				RELATIONSHIP			DATE OF BIRTH			SOCIAL SECURITY NUMBER
ADD	DROP	LAST NAME	FIRST NAME	SPOUSE	CHILD	SEX	MONTH	DAY	YEAR	
☐	☐			☐	☐	☐ Male ☐ Female				
☐	☐			☐	☐	☐ Male ☐ Female				
☐	☐			☐	☐	☐ Male ☐ Female				
☐	☐			☐	☐	☐ Male ☐ Female				
☐	☐			☐	☐	☐ Male ☐ Female				
☐	☐			☐	☐	☐ Male ☐ Female				

REQUESTED COVERAGE CHANGE

☐ MEDICAL INSURANCE	☐ Select Med ☐ Select Med PLUS ☐ Value Care ☐ Value Care PLUS
☐ DENTAL INSURANCE	☐ Silver ☐ Gold Medium ☐ Gold High ☐ Platinum
☐ VISION INSURANCE	☐ Employee only ☐ Two-Party (EE+_____) ☐ Family
☐ FLEXIBLE SPENDING ACCOUNTS	**Health Expense Account:** ☐ Increase from $_____to: $_____ ☐ Decrease from $_____ to: $_____ **Dependent Day Care Account:** : ☐ Increase from $_____to: $_____ ☐ Decrease from $_____ to: $_____ **Card:** ☐ $3.50 charge **No Card:** ☐ $2.00 charge
☐ VOLUNTARY LIFE INSURANCE	☐ Employee Policy: $_____ ☐ Spouse Policy: $_____ ☐ Child(ren) Policy: $_____
☐ VOLUNTARY AD&D INSURANCE	☐ Employee Policy: $_____ ☐ Family Protection Policy: $_____
☐ DISABILITY INSURANCE (CONTRACT ONLY)	
☐ WELFARE ASSOCIATION	

I, the undersigned, hereby make application on behalf of myself and listed legal dependent(s) for membership in the above elected insurance programs of Granite School District. I understand that if this application is accepted, my entitlement to the benefits of said programs will begin as determined by the enrollment regulations of the District. **I understand that enrollment in the plans is binding for the plan/calendar year and that mid-year cancellation is not permitted.** I understand that the medical and dental insurance benefits are part of the Section 125 premium plan and will remain in effect and cannot be revoked or changed during the plan/calendar year unless the change is consistent with a qualified life status change (e.g., marriage, divorce or legal separation, birth/adoption, or placement for adoption, legal guardianship, death, etc.) and the change paperwork and documentation is received by the District Insurance Office within **thirty (30)** calendar days of the qualified life status change occurring. I understand that the medical insurance programs do not cover treatment of pre-existing conditions during the first twelve (12) months following enrollment; except this pre-existing condition waiting period may be reduced by a period(s) of prior creditable coverage. I understand that hospitals, physicians or others shall be required to furnish the benefit provider with information relative to the services they rendered to me or my enrolled legal dependent(s) and may, upon request by the Plan, be asked to furnish additional information such as health status, diagnosis, prognosis, etc. which bear upon such services. I hereby authorize all such information and direct said hospitals, physicians and others to furnish said information in the manner at the time required by the Plan. I accept binding arbitration as the method of resolving any disputes arising between me or my covered legal dependent(s) and the Plan concerning the applicability of benefits payable under the health benefits program including any claim or controversy arising out of or in any way related to the Plan or the administration thereof, whether based on principals of contract, tort, equity or pursuant to statute, including any controversy concerning the scope of validity of the arbitration agreement, Arbitration results in binding decision on all parties, without right of appeal except as permitted by law. I represent and warrant that all information contained in this application for coverage is or will be true. I understand that if such information is untrue or becomes untrue in any material respect, I will be subject to disciplinary action that may include loss of coverage for myself and my legal covered dependents(s).

EMPLOYEE SIGNATURE

Print Form

_____ DATE _____

REV. 07-2013

QUALIFIED LIFE STATUS INSURANCE CHANGE FORM

Terms and Conditions

IRS Section 125 Restrictions
Dependents can only be added or deleted mid-year if a qualified life status change occurs which is consistent with the benefits change that is being made. Notify the District HR Benefits Office of the qualified life status change by completing the required forms within 30 calendar days of the qualified event. If you fail to notify the District HR Benefits Office within **30 calendar days** of the qualified event, you must wait until the next Open Enrollment period in which you are eligible to make the change. Qualified life status changes include marriage, divorce, or legal separation, the birth or adoption of a child, a dependent ceasing to be a dependent, death of a dependent, a change in employment status for you, your spouse or your dependent child.

Requested Documentation
The District HR Benefits Office reserves the right to require proof of dependency upon request. When you sign this form, you agree to provide such documentation upon request.

If you have an eligible dependent who you did not enroll when you were initially eligible or during an Annual Open Enrollment Period (and does not qualify for any of the Special Enrollment provisions), you may enroll the eligible dependent in your medical insurance plan (only) as a Late Enrollee. Coverage for a Late Enrollee will begin the first day of the month following the date the HR Benefits Office receives the required Insurance Change Form.

Release of Information
The District HR Benefits Office will not release any information about you except: 1) when you request it in writing, or 2) when the release is necessary to process or review a claim.

TO ADD A DEPENDENT TO YOUR CURRENT COVERAGE

Marriage: To be covered, your new legal spouse must be added to your coverage within 30 calendar days of your date of marriage. The effective date of coverage will be retroactive to the date of marriage. Attach a copy of the marriage certificate to this form.

Birth: Your new child must be added within 30 calendar days of birth. The effective date of coverage will be retroactive to the date of birth.

Adoption: Your adopted child must be added to your coverage within 30 calendar days of the adoption or placement for adoption. Coverage will be effective the date of the adoption. The District HR Benefits Office must verify the date of adoption by reviewing the adoption documentation. For U.S. adoptions, attach the court signed petition for adoption or adoption decree. For international adoptions, attach a copy of the visa or passport page that identifies the date of U.S. entry and a copy of the adoption orders signed by a magistrate or other government official.

Legal Guardianship - National Qualified child Medical Support Order: When you accept legal guardianship of a child, the child should be added to your coverage within 30 calendar days of the date the petition is signed by the court. A copy of the signed court order must be provided to the District HR Benefits Office for review. Coverage becomes effective on the date the court order is effective, or on the date the child moves into your home, whichever is later.

Job Change or Termination with Loss of Benefits Eligibility-Spouse or Dependent Child: If your spouse or dependent child experiences an employment status change that results in loss of eligibility for coverage, your spouse or dependent child may be added to your coverage within 30 calendar days of the loss of coverage. Your spouse or dependent child must meet established dependent eligibility criteria. Coverage will commence on the date in which the loss of benefits eligibility occurred. A copy of the signed letter from the dependent's employer must be on official company letterhead verifying the loss of coverage date and the type of coverage lost.

FTE Status Change – Granite Employee: If your FTE status changes from part-time to full-time, within 30 calendar days of the FTE status change you may enroll in medical insurance coverage. Coverage will be cancelled on the date in which the FTE status change occurs. The *Insurance Enrollment* form should be used.

TO DROP A DEPENDENT FROM YOUR CURRENT COVERAGE

Death of a Dependent: Provide the date of death of the dependent on this form.

Divorce/Legal Separation: Your spouse and applicable dependent children must be dropped within 30 calendar days from your divorce or legal separation. The effective date of the deletion will be the date your divorce or legal separation was recorded with the Court. Attach a copy of the recorded divorce stamp found on the first/last page of your divorce or legal separation decree.

Loss of Dependent Status - Dependent Child: If your child marries and/or is no longer claimed as your dependent for federal IRS income tax reporting purposes and/or reaches established plan age maximums, the dependent child no longer meets the definition of an eligible dependent. Delete dependent within 30 calendar days of the loss of dependent status. Coverage will be cancelled on the date in which the dependent is no longer deemed an eligible dependent.

Job Commencement or Change with Gain of Benefits Eligibility – Dependent Child: If your dependent child becomes newly eligible for benefits through their employer and no longer meets the definition of an eligible dependent, the child must be removed within 30 calendar days of the coverage effective date under the dependent child's employer plan. Coverage will be cancelled on the date in which the dependent child becomes newly eligible for benefits through their employer. A copy of the signed letter from the dependent's employer must be on official company letterhead verifying the newly eligible effective date of coverage.

FTE Status Change – Granite Employee: If your FTE status changes from full-time to part-time, within 30 calendar days of the FTE status change you may drop medical insurance coverage. Coverage will be cancelled on the date in which the FTE status change occurs.

HOW TO RETURN THE SIGNED AND COMPLETED FORM

By Fax - Keep a copy of the fax transmission report with your form for verification purposes.

FAX NUMBER: 385-646-4319

By Mail – Make a copy for your records and send The original by District Mail or U.S. Mail to:

Granite School District
ATTN: BENEFITS OFFICE
2500 South State Street
Salt Lake City, Utah 84115

Drop it Off in Person – Make a copy for your records and hand deliver to the Benefits Office where your form will be date-stamped 'RECEIVED'.
GEC Administrative Services Building
8:00-5:00 p.m. daily
385-646-4528 or 385-646-4179