

QUALIFIED LIFE STATUS CHANGE FORM

PHONE: 385.646.4528 FAX: 385.646.4319



EMPLOYEE INFORMATION

GRANITE ID	LAST NAME	FIRST NAME	MI
ADDRESS	CITY	STATE	ZIP CODE <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
TELEPHONE NUMBER	EMAIL ADDRESS	DATE OF BIRTH	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED
CLASSIFICATION <input type="checkbox"/> TEACHER <input type="checkbox"/> SECRETARY <input type="checkbox"/> CLASSIFIED <input type="checkbox"/> ADMINISTRATION		FTE	WORK LOCATION
		SUPERVISOR	

QUALIFYING LIFE STATUS CHANGE EVENT

EVENT DATE This form must be received by the DISTRICT BENEFITS OFFICE within 30 calendar days after the qualified event occurred. ALL dependents added will need the <u>appropriate documentation</u> attached to this form.	ADD <input type="checkbox"/> Birth/Adoption (Birth Certificate/Adoption Documents required) <input type="checkbox"/> Legal Marriage (Copy of Marriage Certificate Required) <input type="checkbox"/> Loss of Other Coverage (Copy of Letter Certifying other coverage was lost) <input type="checkbox"/> Granite FTE Status Change (From % to %)	DROP <input type="checkbox"/> Divorce/Legal Separation (Copy of signed/dated court order or decree) <input type="checkbox"/> Death of Dependent (Death Certificate) <input type="checkbox"/> Moving out of Area <input type="checkbox"/> Granite FTE Status Change (From % to %) <input type="checkbox"/> Dependent gains other coverage
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AFFECTED MEMBERS

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

REQUESTED COVERAGE CHANGE

<input type="checkbox"/> MEDICAL INSURANCE	<input type="checkbox"/> SELECT MED 3 TIER	<input type="checkbox"/> VALUE CARE 3 TIER
<input type="checkbox"/> DENTAL INSURANCE	<input type="checkbox"/> GOLD MEDIUM	<input type="checkbox"/> GOLD HIGH
<input type="checkbox"/> VISION INSURANCE (HARDWARE ONLY)	<input type="checkbox"/> PLATINUM LOW	<input type="checkbox"/> PLATINUM HIGH
<input type="checkbox"/> FLEXIBLE SPENDING ACCOUNTS <i>**NO MID-YEAR ADJUSTMENT**</i> CARD COSTS \$3.75 automatically deducted	<input type="checkbox"/> SINGLE	<input type="checkbox"/> TWO-PARTY
<input type="checkbox"/> VOLUNTARY LIFE INSURANCE	<input type="checkbox"/> FAMILY	HEALTH EXPENSE ACCOUNT: <input type="checkbox"/> ANNUAL AMOUNT: \$ _____
<input type="checkbox"/> VOLUNTARY AD&D INSURANCE	<input type="checkbox"/> EMPLOYEE \$ _____	DEPENDENT DAYCARE ACCOUNT: <input type="checkbox"/> INCREASE FROM \$ _____ TO \$ _____
<input type="checkbox"/> VOLUNTARY ACCIDENTAL COVERAGE	<input type="checkbox"/> SPOUSE \$ _____	<input type="checkbox"/> DECREASE FROM \$ _____ TO \$ _____
<input type="checkbox"/> VOLUNTARY CRITICAL CARE	<input type="checkbox"/> EMPLOYEE POLICY: \$ _____	<input type="checkbox"/> CHILD(REN) \$ _____
<input type="checkbox"/> VOLUNTARY HOSPITAL INDEMNITY	<input type="checkbox"/> FAMILY POLICY: \$ _____	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE & SPOUSE
<input type="checkbox"/> VOLUNTARY IDENTITY THEFT PROTECTION	<input type="checkbox"/> EMPLOYEE & CHILD(REN)	<input type="checkbox"/> EMPLOYEE & CHILD(REN)
<input type="checkbox"/> VOLUNTARY PET INSURANCE	<input type="checkbox"/> FAMILY	<input type="checkbox"/> EMPLOYEE & CHILD(REN)
<input type="checkbox"/> DISABILITY INSURANCE (LTD)	<input type="checkbox"/> EMPLOYEE	<input type="checkbox"/> EMPLOYEE & SPOUSE
<input type="checkbox"/> WELFARE ASSOCIATION	<input type="checkbox"/> EMPLOYEE & CHILD(REN)	<input type="checkbox"/> EMPLOYEE & CHILD(REN)
	<input type="checkbox"/> LOW PLAN \$15,000	<input type="checkbox"/> HIGH PLAN \$30,000
	<input type="checkbox"/> INFORMATION EMAILED	<input type="checkbox"/> _____
	<input type="checkbox"/> LTD FOR TEACHERS ONLY	
	<input type="checkbox"/> YES	<input type="checkbox"/> NO --THIS IS ONLY TAKEN UPON DEATH OF A CURRENT EMPLOYEE--

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 of adoption, legal guardianship, death, etc.). The change paperwork and documentation must be received by the District Insurance Office within thirty (30) calendar days of the qualified life status change occurring. 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 up 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 to 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 dependent(s).

Employee Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Effective Date of change: _____
 DUAL COVERAGE: YES NO -- EMPLOYEE: _____
 MEDICAL BM DEP COM PD RECALC
 PRIMARY SECONDARY

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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 Benefits Office of the life status change by completing the required forms within **30 calendar days** of the qualified event. If you fail to notify the Benefits Offices within the **30 calendar days** of the event, you must wait until the next Open Enrollment period in which you are eligible to make the change. Life Status changes include marriage, divorce, birth/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 dependent child.

Requested Documentation

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

Release of Information

The District Benefits Office will not release any information about you except 1) when you request it in writing; 2) when the release is necessary to process or review a claim

ADD OR DROP DEPENDENTS ON 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. A copy of the marriage certificate is required.

Birth

Your new child must be added with **30 calendar days** of birth. The effective date of coverage will be retroactive to the date of birth. A copy of the Birth Certificate is required.

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 Benefits Office must verify the date of adoption by reviewing the adoption documentation. For US 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 US 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 Benefits Office for review. Coverage becomes effective on the date the court order is stamped.

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 stamped first/last page of your decree.

Job Change/Termination

(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/volunteer insurance coverage. Coverage will be cancelled on the date in which the FTE status change occurs.

Loss of Dependent Status – Dependent Child

If your child reaches the established plan age maximum, the dependent child no longer meets the definition of an eligible dependent. Coverage will be cancelled midnight on their 26th birthdate.

Moving Out of Area – Dependent/Retiree

If you or a dependent have moved out of the coverage area, you can drop/change medical plans within **30 calendar days** of the move. Attach a copy of one of the following: utility bill, pay stub, or school enrollment.

Death of a Dependent

Provide the date of death of the dependent on this form and a copy of death certificate.

RETURN THE SIGNED AND COMPLETED FORM

• Fax: 385.646.4319

Phone: 385.646.4528 or 385.646.4179

• Mail: Granite School District
c/o Benefits
2500 South State Street
Salt Lake City, Ut 84115

• Drop off: GEC Benefit Office