QUALIFIED LIFE STATUS CHANGE FORM

PHONE: 385-646-4528 FAX: 385-646-4319

EMPLOYEE INFORMATION

GRANITE ID NUMBER	LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP CODE	☐ Male ☐ Female

TELEPHONE NUMBER	EMAIL ADDRESS	DATE OF BIRTH

EMPLOYMENT CLASSIFICATION	FTE:	WORK LOCATION	SUPERVISOR
☐Teacher ☐Classified ☐Secretary ☐Administrator			

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 ***appropriate documentation*** attached to this form.

ADD

☐ Birth/Adoption
(Birth Certificate/Adoption Documentation Required)

☐ Legal Marriage
(Copy of Marriage Certificate 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

☐ Moving out of Area

☐ Employee gains other coverage
(proof of other coverage start date)

☐ Dependent Gains Other Eligibility
(Copy of Coverage Letter)

☐ Granite FTE Status Change
(From _____% to _____%)

AFFECTED MEMBERS

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

REQUESTED COVERAGE CHANGE

☐ MEDICAL INSURANCE	☐ Select Med 3 Tier ☐ Value Care 3 Tier
☐ DENTAL INSURANCE	☐ Gold Medium ☐ Gold High ☐ Platinum Low ☐ Platinum High ☐ Employee only ☐ Two-Party (EE+_____) ☐ Family
☐ VISION INSURANCE (Hardware only)	☐ Employee only ☐ Two-Party (EE+_____) ☐ Family
☐ FLEXIBLE SPENDING ACCOUNTS *NO MID-YEAR ADJUSTMENT*	**Health Expense Account:** ☐ Annual Amount: $_____to: $_____ **Dependent Day Care Account: :** ☐ Increase from $_____to: $_____ ☐ Decrease from $_____ to: $_____
☐ VOLUNTARY LIFE INSURANCE	☐ Employee Policy: $_____ ☐ Spouse Policy: $_____ ☐ Child(ren) Policy: $_____
☐ VOLUNTARY AD&D INSURANCE	☐ Employee Policy: $_____ ☐ Family Protection Policy: $_____
☐ VOLUNTARY ACCIDENTAL COVERAGE	☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family
☐ VOLUNTARY CRITICAL CARE	☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family ☒ Low Plan $15,000 ☐ High Plan $30,000
☐ VOLUNTARY HOSPITAL INDEMINITY	☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family
☐ VOLUNTARY IDENTITY THEFT PROTECTION	☐ Employee ☐ Family
☐ DISABILITY INSURANCE (Long Term)	☐ TEACHERS ONLY
☐ WELFARE ASSOCIATION	☐ Yes ☐ No – This is only taken upon the 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 for 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 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: _____ DATE _____ REV. 06-2024

FOR BENEFIT OFFICE USE ONLY

Effective Date of Change:_____ ☐ NAVIGATOR ☐ QSS ☐ DEP ☐ COM ☐ PD ☐ RECALC

DUAL COVERAGE: ☐ YES ☐ NO -- EMPLOYEE: ☐ PRIMARY ☐ SECONDARY

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 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 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
- MAIL: Granite School District
  % Benefits
  2500 South State Street
  Salt Lake City, Utah 84115
- Drop off: GEC Benefit Office