HARMONY PUBLIC SCHOOLS

Qualifying Life Event Form

Employee Benefits Change Request

Employee Information

Full Name: _____ Employee ID (EID): _____

Email: _____ Campus / Location: _____

Qualifying Life Event Details

Type of Qualifying Event

- ☐ Marriage
- ☐ Birth of Child
- ☐ Loss of Other Coverage
- ☐ Death of Dependent
- ☐ Other _____
- ☐ Divorce / Legal Separation
- ☐ Adoption / Placement for Adoption
- ☐ Gain of Other Coverage
- ☐ Change in Employment Status

Qualifying Life Event Date: _____

QLE Description: _____

Dependent Information

Dependent Name	Relationship	Date of Birth	Sex	SSN (Full)	PCP and PCP ID#

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Employee Benefits Change Request

Medical

Active Care HD

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Active Care Primary

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Active Care Primary Plus

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Dental

Cigna DHMO

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Ameritas PPO

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

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Employee Benefits Change Request

Other Benefits

Vision

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Long-Term Disability (LTD)

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only

Life Insurance ☐ Permanent ☐ Term

Action: ☐ Add ☐ Remove ☐ Change Policy Amount Requested: _____

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Health Savings Account (HSA)

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Family

Monthly Deduction Amount Requested: _____

Flexible Spending Account (FSA)

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Family

Monthly Deduction Amount Requested: _____

Critical Illness

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Cancer Insurance

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Accident Insurance

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

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Employee Benefits Change Request

Other Benefits (continued)

Hospital Indemnity

Action: ☐ Add ☐ Remove ☐ Change

Coverage: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

Documentation

Supporting documents attached: ☐ Yes ☐ No

(Examples: marriage certificate, birth certificate, loss of coverage letter, etc.)

Employee Certification

I certify that the information provided is accurate and that this request is due to a qualifying life event. I understand that changes must be consistent with the event and submitted within the required timeframe. I acknowledge and agree to the applicable premiums as outlined in the Benefits Guide and/or benefits website. I understand that effective dates will be determined based on plan rules.

Employee Signature: _____ Date: _____

Benefits Dept Use Only

Date Received: _____ ☐ **Approved: Yes** ☐ **No**

Processed By: _____