



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#
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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

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: