



EMPLOYEES BENEFITS DEPARTMENT OF HCM
of the Office of Management and Enterprise Services

Change Request Form



COORDINATOR USE ONLY (Must complete)

Event Date ____/____/____

Requested Effective Date ____/01/____

This Effective date will be the first of the month following the notice date unless the change is a birth or adoption. The event date and the effective date cannot be the same (except in the case of birth or adoption).

Benefits Office USE ONLY

Approved
AWDOC/Date ____/____/____
 Returned/Date ____/____/____
 Denied
Effective Date ____/01/____

Benefits Office
Authorization

Employee Information Please Print or Type		Payroll/Employee ID:		SSN	<input type="checkbox"/> Married <input type="checkbox"/> Single
Last Name	First Name	Middle Initial	Email	Phone ()	
<input type="checkbox"/> New Home Mailing Address Address?	City		State	Zip	
My spouse is	<input type="checkbox"/> State	<input type="checkbox"/> Education	<input type="checkbox"/> County Employee	Name	SSN

Agency	Name	Agency #	Location Code	Work Phone ()
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Change Reasons (Please attach supporting documentation to this Change Request Form)

The **EVENT DATE IS** ____/____/____ and I have circled the appropriate exception number below. By signing this document I am indicating that I wish to make a change to my benefit options under the Plan. I hereby affirm this change is due to the allowable midyear change as checked below. I understand that I have 30 days from the indicated event date to request applicable changes to my benefit options for this Plan Year.

Allowable Midyear Changes within Plan Guidelines are listed below.

- | | |
|--|--|
| <input type="checkbox"/> 1. Marital status (Marriage/divorce/separation-documentation required)
<input type="checkbox"/> 2. Number of Dependents
<input type="checkbox"/> 3. Employment Status affecting eligibility for employee, spouse or dependent
<input type="checkbox"/> 4. Dependent Eligibility , no longer tax eligible dependent per IRS Code 152
<input type="checkbox"/> 5. Change of Residence for employee or dependent
<input type="checkbox"/> 6. Adoption Proceedings, starting or ending | <input type="checkbox"/> 7. Judgments, Decrees/Orders (allowed for Health, HCRA & Dental)
<input type="checkbox"/> 8. Medicare or Medicaid (allowed for Health & HCRA only and limited to two [2] changes per year for Medicaid)
<input type="checkbox"/> 9. Dependent Care Significant Cost/Coverage Change
<input type="checkbox"/> 10. Employer Plan Coverage Change for spouse or dependent(s)
<input type="checkbox"/> 11. FMLA leave
<input type="checkbox"/> 12. Other , specify (Administrative, Adjustments, etc.) |
|--|--|

Change

(a) <input type="checkbox"/> TERMINATION	<input type="checkbox"/> DEATH <input type="checkbox"/> DISCHARGE <input type="checkbox"/> RESIGNATION <input type="checkbox"/> RETIREMENT <input type="checkbox"/> USERRA <input type="checkbox"/> VOBO	Last Date on Payroll
(b) <input type="checkbox"/> TRANSFER	From Agency # &Location Code Payroll End To Agency #	& Location Code Payroll Begin
(c) <input type="checkbox"/> EMPLOYMENT STATUS	<input type="checkbox"/> REHIRE <input type="checkbox"/> LWOP <input type="checkbox"/> WORKER'S COMP <input type="checkbox"/> DISABILITY <input type="checkbox"/> FMLA (Family Leave)	Date Left Date Returned
(d) <input type="checkbox"/> CORRECTION	<input type="checkbox"/> NAME <input type="checkbox"/> SSN <input type="checkbox"/> BIRTHDATE	From To For
(e) <input type="checkbox"/> DROPPED COVERAGE for Non-Payment of premiums	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> DEPENDENTS	Effective Date ____/01/____ Reason
(f) <input type="checkbox"/> PLAN CHANGE If any qualifying exception or administrative error requires or results in a plan change, designate below the new plan and new PCP or PCD.		
From (Current Plan)	To (New Plan)	PCP/PDP Effective Date ____/01/____



Change cont. Last name _____ Date _____ SSN _____

(g) <input type="checkbox"/> REIMBURSEMENTS		Current	Change to
ACCOUNTS	DEPENDENT CARE (Monthly minimum=\$50, Monthly maximum = \$416.66)	\$ _____	\$ _____
	HEALTH CARE (Monthly minimum=\$10, Monthly maximum = \$208.33)	\$ _____	\$ _____

Employee/Dependent Information Complete and check coverage boxes
List only individuals being added or dropped on the health, dental, vision &/or dependent life plans.

Spouse Add <input type="checkbox"/> Drop <input type="checkbox"/> <input type="checkbox"/> Health <input type="checkbox"/> <input type="checkbox"/> Dental <input type="checkbox"/> <input type="checkbox"/> Vision <input type="checkbox"/> <input type="checkbox"/> Dep Life <input type="checkbox"/>	Name	SSN		
	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F		
	Address	City	State	Zip
	Plan Name:	Primary Care Physician		
	<input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low	Primary Care Dentist		

Child Add <input type="checkbox"/> Drop <input type="checkbox"/> <input type="checkbox"/> Health <input type="checkbox"/> <input type="checkbox"/> Dental <input type="checkbox"/> <input type="checkbox"/> Vision <input type="checkbox"/> <input type="checkbox"/> Dep Life <input type="checkbox"/>	Name	SSN		
	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F		
	Address	City	State	Zip
	Plan Name:	Primary Care Physician		
	<input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low	Primary Care Dentist		

Child Add <input type="checkbox"/> Drop <input type="checkbox"/> <input type="checkbox"/> Health <input type="checkbox"/> <input type="checkbox"/> Dental <input type="checkbox"/> <input type="checkbox"/> Vision <input type="checkbox"/> <input type="checkbox"/> Dep Life <input type="checkbox"/>	Name	SSN		
	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F		
	Address	City	State	Zip
	Plan Name:	Primary Care Physician		
	<input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low	Primary Care Dentist		

Employee Authorization

I authorize and agree to any NECESSARY salary reduction to implement my elections. **I UNDERSTAND MY ELECTIONS ARE BINDING AND IRREVOCABLE AND WILL REMAIN IN EFFECT FOR THE FULL PLAN YEAR UNLESS I EXPERIENCE AN ALLOWABLE MIDYEAR CHANGE EVENT.** I understand that I have 30 days from the event to request any applicable changes to my options for this Plan Year. I also understand that any money left in the reimbursement account(s) will be forfeited at the end of the Plan Year grace period or upon my termination with the State.

Employee Signature: **X** _____ Date: _____ / _____

Agency & Group

Benefits Coordinator Authorization, please date & sign.

The original enrollment form must be sent to the Employees Benefits Department of HCM accompanied by any additional documentation for enrollment as required (i.e. Exclusion for Spouse Coverage, proof of other group coverage, Supplemental Life applications, etc.) If all requested information is not completed on this form by either the employee or the Coordinator, the form will be returned for completion, which could result in a delay in processing and/or denial of claims.

Benefits Coordinator: **X** _____ Phone: (____) _____ Date: _____

BC Email: _____

IMPORTANT! Send Original form and all attachments to the Employees Benefits Department of HCM