



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
<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

EMPLOYEE ONLY	<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	
(a) <input type="checkbox"/> TERMINATION	From Agency #	&Location Code	End Date	To Agency #	& Location Code	Begin Date
(b) <input type="checkbox"/> TRANSFER	<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
(c) <input type="checkbox"/> EMPLOYMENT STATUS	<input type="checkbox"/> NAME	<input type="checkbox"/> SSN	<input type="checkbox"/> BIRTHDATE	From	To	For
(d) <input type="checkbox"/> CORRECTION	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> DEPENDENTS		Effective Date ____/01/____	Reason		
(e) <input type="checkbox"/> DROPPED COVERAGE for Non-Payment of premiums	(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/____			
(g) <input type="checkbox"/> REIMBURSEMENTS ACCOUNTS	Current		Change to			
<input type="checkbox"/> Benny Card	DEPENDENT CARE (Annual minimum=\$600, Annual maximum = \$5,000)	\$ _____	\$ _____			
	HEALTH CARE (Annual minimum=\$120, Annual maximum = \$2,550)	\$ _____	\$ _____			

Change cont. Last name _____ Date _____ SSN _____

(h) <input type="checkbox"/> HEALTH SAVINGS ACCOUNT – HSA (To be used in conjunction with the HDHP)	Current \$ _____	Change to \$ _____
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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: <input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low	Primary Care Physician		
		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: <input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low	Primary Care Physician		
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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: <input type="checkbox"/> Premier <input type="checkbox"/> Standard <input type="checkbox"/> Low	Primary Care Physician		
		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 date 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 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 form and all attachments to the Employees Benefits Department of HCM