



## Flexible Benefits Program Qualifying Change in Status Form

Please read the Terms and Conditions on the back of this form prior to completing.

Type or print clearly in ink and return to your personnel or payroll office.

<b>Employee Information</b> (Please complete in full the requested information below)		<b>Reason for Change(s) in Coverage</b> Check the box that best describes the reason for this action and give the date of the qualifying event. Attach documentation supporting your qualifying event request.	
Social Security Number	Date of Birth (00/00/0000)	Date of Event _____  <input type="checkbox"/> Marriage/Marriage Causing Dual Coverage <input type="checkbox"/> Legal Separation <input type="checkbox"/> Divorce <input type="checkbox"/> Loss of all Eligible Dependents <input type="checkbox"/> Gain of Eligible Dependents <input type="checkbox"/> Loss/Gain of Spouses Coverage – Employment Change <input type="checkbox"/> Moving from Dental PPO Service Area <input type="checkbox"/> Qualified Medical Child Support Order <input type="checkbox"/> Qualified Medical Child Support Order <input type="checkbox"/> Other (Please List) _____ _____ _____	
Last Name		First Name	
Street Address		Middle Initial	
City/State/Zip Code/County			
Apt/Box/Route Number	Daytime Phone Number (    )		

**Dependent Information:** Specify each eligible dependent to be covered, if applicable. Attach additional sheet, if necessary

Dependent's Full Name	Social Security Number	Date of Birth	Relationship

**Coverage Change(s)** Specify the current Level of Coverage and the new Requested level. Check with your Personnel Office regarding Medical Underwriting. \*\*\*NOTE: Please mark Experienced Qualifying Event on any Evidence of Insurability form submitted to Minnesota Life

<b><u>Employee Life</u></b> _____ Current Coverage Level _____ Requested Coverage Level	<b><u>Spouse Life</u></b> _____ Current Coverage Level _____ Requested Coverage Level	<b><u>Child Life</u></b> _____ Current Coverage Level _____ Requested Coverage Level
<b><u>Short-Term Disability</u></b> _____ Current Coverage Level _____ Requested Coverage Level	<b><u>Long-Term Disability</u></b> _____ Current Coverage Level _____ Requested Coverage Level	<b><u>Vision</u></b> _____ Current Coverage Level _____ Requested Coverage Level

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**Accidental Death & Dismemberment**

\_\_\_\_\_ Current Coverage Level  
\_\_\_\_\_ Requested Coverage Level

**Legal**

\_\_\_\_\_ Current Coverage Level  
\_\_\_\_\_ Requested Coverage Level

**Dental**

\_\_\_\_\_ Current Coverage Level  
\_\_\_\_\_ Current Coverage Type  
\_\_\_\_\_ Requested Coverage Level  
\_\_\_\_\_ Requested Coverage Type

**Long-Term Care**

\_\_\_\_\_ Current Coverage Level  
\_\_\_\_\_ Included Additional Coverage Option (if Applicable)  
\_\_\_\_\_ Requested Coverage Level  
\_\_\_\_\_ Included Additional Coverage Option (if Applicable)

**Dependent (Child) Care Spending Account (DCSA)**

\_\_\_ Enroll in DCSA: Monthly Contribution \$\_\_\_\_\_ (monthly)  
\_\_\_ Increase Contribution from \$\_\_\_\_\_ to \$\_\_\_\_\_ (monthly)  
\_\_\_ Decrease Contribution from \$\_\_\_\_\_ to \$\_\_\_\_\_ (monthly)  
\_\_\_ Discontinue DCSA Coverage

**Health Care Spending Account (HCSA)**

\_\_\_ Enroll in HCSA: Monthly Contribution \$\_\_\_\_\_ (monthly)  
\_\_\_ Increase Contribution from \$\_\_\_\_\_ to \$\_\_\_\_\_ (monthly)  
\_\_\_ Decrease Contribution from \$\_\_\_\_\_ to \$\_\_\_\_\_ (monthly)  
\_\_\_ Discontinue HCSA Coverage

**Specified Illness**

\_\_\_\_\_ Current Coverage Level  
\_\_\_\_\_ Requested Coverage Level

**Health Insurance**

\_\_\_\_\_ Current Coverage Level  
\_\_\_\_\_ Current Coverage Type  
\_\_\_\_\_ Requested Coverage Level  
\_\_\_\_\_ Requested Coverage Type

\*Note: Employees must still complete a State Health Benefit Plan Membership Form and submit to the State Health Benefit Plan. GMS does not approve Health changes.

**Authorization: I have read and agree with the Terms and Conditions provided below this form. I certify that the above information and any attachments are true and correct. I understand that any misrepresentation or falsification will subject me to penalties and possible legal action. My signature below authorizes this form to be faxed or mailed to the Georgia Merit System.**

**Employees Signature \_\_\_\_\_ Date \_\_\_\_\_**

# Qualifying Change of Status Form

## Terms and Conditions

### Policy Information

The Flexible Benefits Program functions as an Internal Revenue Code, Section 125, "cafeteria plan." Under IRS regulations and Rules of the Employee Benefit Plan Council, benefit elections made by employees during an Open Enrollment Period are binding for the duration of the Plan Year. Only under limited conditions of a qualifying "Change in Status" are employees allowed to enroll/ increase or cease/decrease some coverage outside an Open Enrollment Period. A benefit election change will only be permitted if approved by your Department's Benefit Coordinator.

### General Information

This form is to be used by an employee who is requesting a change in benefits due to a qualifying "Change in Status." When a Change in Status occurs, the employee is to complete the applicable areas of this form and return it to his/her department within the specified time frames described below. You must also attach documentation supporting your request. **Please note that if an employee is requesting a change in Health Insurance due to a Qualifying Change in Status, the employee must complete a State Health Benefit Plan Membership Form.** If the employee is requesting to enroll/increase coverage, the request must be made within 31 days. If the employee is requesting to cease/decrease coverage, the request must be made within 90 days. If additional clarification is needed, please call the Flexible Benefits Program at (404) 656-2730, if it is a local Atlanta call, or toll-free at 1 (888) 968-0490, if calling outside the local area.

### Effective Date of Change of Coverage

Changes will go into effect the first of the month following the date when the payroll is changed to reflect the employee's new choice.

### Qualifying Events

Events that may permit you to enroll or change one or more coverage options:

- a) you gain or lose a spouse; or
- b) you gain or lose an eligible dependent; or
- c) your spouse or dependent becomes eligible for or loses coverage under another employer's plan, COBRA or a governmental plan; or
- d) an event causes your dependent to gain or lose eligibility for coverage under your employer's plan; or
- e) your change of residence causes you, your spouse, or dependents to gain or lose eligibility for coverage under your plan or another employers plan; or
- f) the cost of your Dependent Care increases or decreases significantly and your dependent care provider is not related to you, your spouse, or your dependent; or
- g) your spouse's employer increases, decreases, or ceases coverage, or conducts Open Enrollment; or
- h) you, your spouse or your dependent gain or lose eligibility for Medicare or Medicaid.

#### For Department Use Only:

Request is: **Approved** \_\_\_\_\_ **Denied** \_\_\_\_\_ **Partial Approval/Denial** \_\_\_\_\_ (Make Comments Below)

Comments \_\_\_\_\_

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Mail to: Georgia Merit System  
Flexible Benefits Division  
2 Martin Luther King Jr. Drive  
1016 West Tower  
Atlanta, Georgia 30334

**OR**

Fax Copy to: Flexible Benefits Program  
(404) 463 - 6379