Qualifying Event Form

Central Maine Healthcare
Compensation & Benefits

NAME DEPT SSN DATE

You can make changes to your benefits during the year based on certain life events such as changes in your family including employment status changes or loss or addition of coverage elsewhere. In all cases, the change in coverage you request must be consistent with the life change.

In accordance with IRS guidelines, you have 30 days from the event to make changes to your elections by submitting this completed form and the indicated documentation to Human Resources. If you do not notify HR within 30 days of the change, you will not be able to modify your coverage levels until the next open enrollment period.

Date of Event	Qualifying Event	**Documentation Required**	Effective Date of Coverage Change
	Change in Marital Status ☐ Marriage ☐ Legal separation ☐ Divorce	• Copy of marriage license or certificate • Copy of separation or annulment paperwork • Copy of divorce decree	First of the month following event
	Birth/Adoption/Custody of a Child	• Copy of birth certificate or hospital certificate • Copy of adoption or custody verification documentation	Date of birth/adoption/custody
	Loss of coverage Explanation:	• Documentation verifying date coverage ended AND • If adding new dependents, copy of documentation proving relationship (marriage license or birth certificate, etc)	First of the month following the loss of coverage
	Acquired new coverage elsewhere Explanation:	• Documentation verifying date new coverage began	First of the month following the addition of coverage
	Establishment/Termination of Domestic Partnership	• Completion of partner agreement form and submission of acceptable evidence	First of the month following the establishment/ termination
	Change In Dependent Care Provider	• Documentation showing the change in provider	First pay period following the change

Rates and plan information can be found at cmmfhealthydecisions.com.
Questions? Contact hrbenefits@cmhc.org

	Name (Fill in names of anyone who is currently enrolled on your insurance or who you are adding)	SSN	Sex (M/F)	Date of Birth (MM/DD/YY)	Current Coverage				New Coverage			
					Medical	Dental	Vision	Dep. Life Insurance	Medical	Dental	Vision	Dep. Life Insurance
Self					☐	☐	☐		☐	☐	☐	
☐ Spouse Or ☐ DP					☐	☐	☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐	☐	☐

MEDICAL COVERAGE ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

- Choose your plan (choose one):
  - ☐ Enroll in $500 deductible plan
  - ☐ Enroll in $1500 deductible plan

- Employment status:
  - ☐ Full time employee (30+ hours/week)
  - ☐ Regular part time employee (20-29 hours/week) (add $25 bi-weekly)

- Are you (and your spouse/domestic partner, if covered on medical insurance) committing to participating in the healthy decisions wellness program?
  - ☐ Yes ($30 bi-weekly discount)
  - ☐ No

- Are you enrolling any tobacco users on our Medical Plan?
  - ☐ No ($25 bi-weekly discount)
  - ☐ Yes, but all covered tobacco users will commit to completing a tobacco cessation program ($25 bi-weekly discount)
  - ☐ Yes, and they will not commit to tobacco cessation

FOR DENTAL OR VISION, notate coverage on dependent chart above

DEPENDENT LIFE INSURANCE ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

You may make changes to coverage due to birth of a child or marriage

- Choose your level of coverage if adding dependent life:
  - ☐ $5,000 spouse and/or $2,000 child(ren)
  - ☐ $10,000 spouse and/or $5,000 child(ren)
  - ☐ $20,000 spouse and/or $10,000 child(ren)
  - ☐ $50,000 spouse and/or $10,000 child(ren)
  - ☐ No change

FLEXIBLE HEALTHCARE SPENDING ACCOUNT ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

- Select coverage
  - ☐ I would like to enroll/ change my semi-monthly contribution to $_____ (this amount will be deducted 2x a month- can contribute between $100-$2600 annually)
  - ☐ No change

- Reimbursement type (choose one)
  - ☐ Benny card
  - ☐ Automatic reimbursement
  - ☐ Neither

DEPENDENT CARE SPENDING ACCOUNT ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

- ☐ I would like to enroll/ change my semi-monthly contribution to $_____ (this amount will be deducted 2x a month- can contribute between $100-$5000 annually)
- ☐ No change

SIGNATURE

By signing below, I commit to the accuracy of this information. I understand falsifying this form can result in loss of coverage, additional premiums, and further disciplinary action up to and including termination.

I authorize the elections I have made and the payments required for those elections. I understand that any payroll deductions will be made from my paycheck. I also understand that the elections cannot be changed unless I have a qualifying event.

SIGNATURE DATE

Please return this enrollment form to CMMC Human Resources by interoffice mail, fax to 795-2385, email to HRbenefits@cmhc.org, or drop off at 29 Lowell St. 4th Floor within 30 days of your qualifying event.