



Qualifying Event Form

Employee Name		Department	
Employee #		Social Security #	
Effective Date		Hospital #	

Type of Qualifying Event	Date of Event
Marriage, legal separation, divorce	
Birth or adoption of a child	
Death of a family member	
Loss/change of spouse's employment status	
Employee change in hours/status	
To coordinate with spouse's open enrollment	
Change In Dependent Care Provider	
Medicare or Medicaid eligibility	
Establish or termination of a Domestic Partnership	
Child eligible or no longer eligible	

Documentation to Substantiate Event and/or Dependents (copies must be provided with Qualifying Event)
Copy of the first page of your last federal income tax return showing the child and/or spouse listed as your dependent.
Copy of your child's legal birth certificate naming your/your spouse/your domestic partner as the child's parent.
Copy of legal adoption papers issued by the courts naming your/yours spouse/your domestic partner as the child's parent.
Copy of legal guardianship issued by the courts.
Copy of a court order naming you/your spouse/your domestic partner as the child's foster parent. All documents must include the following information: name of the dependent and foster parent, official signature and court seal/stamp.
Copy of a Qualified Medical Child Support Order (QMCSO) showing you are required to provide coverage for the child. All documents must state your current employer's name, and include the names of the dependent child and parent.
To prove a domestic partner relationship you must submit an evidence of civil union or Evidence of registration as a domestic partnership or family unit in any state of municipality that offers such registration. If you do not have either of these documents you must provide three documents such as: Joint lease, mortgage, or deed dated within the past 12 months, joint ownership of checking or credit account statement dated within the past 12 months (i.e.: phone bill, utility bill, cable bill), joint ownership of a vehicle, designation of partner as beneficiary of insurance/pension, designation of partner as beneficiary in Employee's will or designation of partner as holding power of attorney for healthcare.

Family Member(s) Affected				
Name	SSN	Gender	Date of Birth	Relationship

Benefit	Current Coverage	Current Bi-Weekly Deduction	New Coverage	New Bi-Weekly Deduction	"X" to Keep the same
Health Insurance					X
Dental Insurance					X
Vision Insurance					
Basic Life/AD&D	Enrolled (1x salary)	\$0.00		\$0.00	X
Supplemental Life Insurance					X
Dependent Life Insurance					X
Basic 50%LTD Insurance Tax Free Benefit					X
Basic 50% LTD Insurance Taxed Benefit					X
Supp LTD Insurance (10%)					X
Healthcare Spending Acct					X
Dependent Care Acct					X

Employee Signature _____ Date _____