MARANA AZ
HUMAN RESOURCES

Benefit Change Form

Please complete this form if you and/or your dependents have experienced a qualifying life event that will affect your benefit(s) status outside of the annual open enrollment period OR to change the contribution amount to your Health Savings Account.

Employee Information:

Name _____ **EID**_____ **Department** _____ **Date** _____

Address _____ **City/State** _____**Zip Code** _____

In order to process your request, this form must be completed and submitted to the Human Resources Department within 30 days from the date of the qualifying life event, along with documentation to support the family status change reason. Requests will be processed in accordance with IRS regulations and consistent with the provisions of the Town of Marana Plan.

Eligible dependents: An Employee's spouse under a legally-valid existing marriage and/or an employee's children or those of his/her spouse, including newborn children, legally-adopted or step children, children to whom you are the legal guardian, substantiated by a court order. Dependent child(ren) will be covered until his or her twenty-sixth (26th) birthday regardless of marital status, residency, financial dependency, or student status.

Date of qualifying life event: _____ **Benefit change effective date:** _____

Please mark the appropriate box:

- ☐ Marriage of employee (copy of marriage certificate and driver's license or social security card)
- ☐ Divorce of employee (copy of divorce decree and new mailing address for the ex-spouse, for the Cobra packet to be mailed): _____
- ☐ Birth/Adoption/Legal Guardianship of Child (copy of birth certificate/adoption papers/legal guardianship papers).
- ☐ Death of Spouse or Child (copy of Death Certificate) a certified Death Cert. will be required for a Life Insurance Claim.
- ☐ Start of employee's or dependent's benefits with another provider (copy of Certificate of Creditable Coverage).
- ☐ Termination of employee's or dependent's benefits with another provider (Employer/Provider document with change indicated).
- ☐ Employee changing from part-time to full-time or full-time to part-time (document from Employer).
- ☐ Employee/Spouse taking an unpaid leave of absence (document from Employer).
- ☐ Issuance of qualified medical child support order (copy of court order).
- ☐ Change in residence of Employee, Spouse, or Child that is outside of the service area of the current enrolled plan (proof of residence).
- ☐ Health Savings Account (H.S.A) deferral change
  NOTE: Changes to H.S.A. elections will take one full pay period to process
- ☐ Other (please explain and provide documentation) _____

FOR HUMAN RESOURCE USE ONLY: Change Form Received _____ PP Effective Date: _____

☐Documentation received ☐ Munis Entry ☐Provider Entry ☐Beneficiaries (Life/Retirement) ☐Cobra notification (if applicable)

Coverage Plans: You are required to elect or waive each type of coverage. Please select the coverage that you will be changing as a result of the qualifying event:

Coverage	Waive/Terminate Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
BCBS Copper	☐ waive	☐	☐	☐	☐
BCBS Teal	☐ waive	☐	☐	☐	☐
BCBS Heritage (HD/H.S.A)	☐ waive	☐	☐	☐	☐
Dental					
Delta Dental Base Plan	☐ waive	☐	☐	☐	☐
Delta Dental Plus Plan	☐ waive	☐	☐	☐	☐
Vision					
Superior Vision	☐ waive	☐	☐	☐	☐
Health Savings Account Changes to H.S.A. elections will take one full pay period to process	☐ not applicable	Current pay period election: Amount: $_____		New per pay period: Election:$_____	
Flexible Spending Account					
Health Care Account	☐ not applicable	Current pay period Election: Amount: $_____		New pay period Election: $_____	
Dependent Care Account	☐ not applicable	Current pay period Election: Amount: $_____		New pay period Election: $_____	
Supplemental Life Insurance/STD Buy-Up					
Employee Life Insurance Buy-Up	☐ not applicable	Current Election: $_____		New Election (10k increments) $_____	
Spouse Life Insurance Buy-Up	☐ not applicable	Current Election: $_____		New Election (5k increments) $_____	
Child Life Insurance Buy-Up	☐ not applicable	Current Election: $_____		New Election (2k increments) $_____	
Short Term Disability Buy-Up	☐ not applicable	Waive Coverage ☐		Reinstate Coverage ☐	

Dependents: Enter the following information for each dependent you wish to add/remove to your coverage.
M=Medical D=Dental V=Vision LI=Life Insurance Buy-Up

	Name	Relationship	Social Security #	Date of Birth	Gender	M	D	V	LI
Add ☐ Remove ☐					M ☐ F ☐	☐	☐	☐	☐
Add ☐ Remove ☐					M ☐ F ☐	☐	☐	☐	☐
Add ☐ Remove ☐					M ☐ F ☐	☐	☐	☐	☐
Add ☐ Remove ☐					M ☐ F ☐	☐	☐	☐	☐

Your signature acknowledges that you understand and accept that selected elections will remain in place until the next benefits open enrollment period and that election changes are only allowed as consistent with the plan rules.

Participant Signature:_____ **Date:** _____