QUALIFYING LIFE EVENT AND BENEFIT CHANGE FORM

TPA EXCHANGE

EMPLOYER:	DATE OF CHANGE:
LOCATION:	

TYPE OF CHANGE:	☐ NAME	☐ ADDRESS	☐ QLE	☐ PHONE	☐ EMAIL	☐ BENEFICIARY

EMPLOYEE LAST NAME:	FIRST NAME:	MIDDLE:	DOB (MM/DD/YY)	SOCIAL SECURITY #

EMPLOYEE MAILING ADDRESS: STREET	APT #	CITY	STATE	ZIP CODE

EMAIL ADDRESS:	PHONE NUMBER:	GENDER:
		M: ☐ F: ☐

Events consistent with adding family members to coverage:

- ☐ Marriage (Certified marriage certificate)
- ☐ Birth or Adoption (Birth certificate/hospital announcement or adoption agreement)
- ☐ Judgment, Decree, or Order to Add Child (Court order)
- ☐ Lost eligibility Under Governmental Plan (Government documentation)
- ☐ Lost eligibility Under Medicare or Medicaid (Government documentation)
- ☐ Spouse or Child Lost Eligibility Under Their Employers Plan (Employer documentation)

Events consistent with removing family members from coverage:

- ☐ Divorce (Divorce decree)
- ☐ Death of Spouse (Documentation validating death)
- ☐ Death of Child (Documentation validating death)
- ☐ Child Covered Under Plan Lost Eligibility (Documentation to support)
- ☐ Judgment, Decree or Order to Remove Child (Court order)
- ☐ Gained Eligibility Under Medicare or Medicaid (Government Documentation)
- ☐ Spouse or Child Gained Eligibility Under Their Employers Plan (Employer documentation)

Other events:

- ☐ Employment Change: ☐ Full-Time to Part-Time ☐ Part-Time to Ful-Time
- ☐ Unpaid Leave Began
- ☐ Unpaid Leave Ended
- ☐ Dependent Care Cost or Coverage Change (Documentation from dependent care provider)
- ☐ HIPAA Special Enrollment Due to Loss of Other Coverage (HIPAA Certificate)
- ☐ Move Affecting Eligibility for Health Care Plan (Agency validates move)
- ☐ Other Employers Open Enrollment or Plan Change (Employer documentation)
- ☐ Enrollment in a Marketplace Exchange Health Plan (Documentation of the Marketplace coverage enrollment and the effective date of coverage)

ADD COVERAGE FOR:	☐ SPOUSE	☐ CHILD	☐ CHILDREN	☐ FAMILY
TERMINATE COVERAGE FOR:	☐ SPOUSE	☐ CHILD	☐ CHILDREN	☐ FAMILY

DEPENDENTS

	LAST NAME	FIRST NAME	SEX	DOB (MM/DD/YY)	SOCIAL SECURITY #
SPOUSE:					
CHILD:					
CHILD:					
CHILD:					
CHILD:					
CHILD:					

CHANGE PLAN ELECTION TO:

PLEASE CHECK ONE OPTION:	DEDUCTIBLE LEVEL:	NETWORK:
VISIT LIMIT	CHOICE OF: ☐ $500 ☐ $750 ☐ $1,000 ☐ $1,500	☐ PHCS ☐ MAGNACARE
MAJOR MEDICAL	CHOICE OF: ☐ $1,000 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $7,350	☐ PHCS ☐ MAGNACARE
HSA MAJOR MEDICAL	CHOICE OF: ☐ $2,500 ☐ $3,500 ☐ $5,000	☐ PHCS ☐ MAGNACARE
COPAY PPO	CHOICE OF: ☐ $500 ☐ $750 ☐ $1,000 ☐ $1,500	☐ PHCS ☐ MAGNACARE

OTHER COVERAGE INFORMATION:

DO YOU OR YOUR DEPENDENTS HAVE OTHER MEDICAL COVERAGE UNDER ANOTHER HEALTH PLAN SUCH AS AN EMPLOYER SPONSORED GROUP HEALTH PLAN OR HMO, INDIVIDUAL POLICY, MEDICARE, MEDICAID, OR CHAMPUS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE:

CARRIER: _____ EFFECTIVE DATE: _____ GROUP #: _____

AUTHORIZATION

I HEREBY REQUEST COVERAGE UNDER THE GROUP POLICY(IES) ISSUED BY MY EMPLOYER'S HEALTH PLAN. I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS ANY REQUIRED CONTRIBUTIONS. I AM AN ELIGIBLE EMPLOYEE MEETING THE REQUIREMENTS OF PARTICIPATION WITH MY EMPLOYER. I UNDERSTAND THAT MY ELECTION OF COVERAGES ABOVE DOES NOT AUTOMATICALLY GUARANTEE THAT COVERAGE IS IN FORCE. ALL ELIGIBILITY REQUIREMENTS OF THE POLICY(IES) MUST BE PROPERLY SATISFIED BEFORE COVERAGE BECOMES EFFECTIVE AND TO REMAIN ACTIVE.

EMPLOYEE SIGNATURE (REQUIRED): _____ **DATE (REQUIRED):** _____