Qualifying Life Event (QLE) Change Request

Employee Name: _____ **QLE Effective Date:** _____

Benefit Change Request Instructions

☐ **Complete the below information <u>within 30 days of the QLE date</u> including:**

- Type of Qualifying Life Event
- Attach supporting documentation
- Review 2024 rate sheet for applicable benefit rates
- Waiver or enrollment of available benefits
- Applicable Spouse/Dependent information

QLE Type and Supporting Documentation

☐ Marriage (Marriage Certificate)
☐ Divorce (Divorce Decree)
☐ Birth/Adoption (Birth or Adoption Certificate)
☐ Death (Death Certificate)
☐ Loss of Other Coverage (Letter or COBRA)
☐ Eligibility for Other Coverage (Letter)
☐ Other

Benefits Enrollment/Changes (rates are semi-monthly)

Medical	**Medical Plan** ☐ Traditional ☐ HSA (Blue Saver) ☐ BlueSelect Plus	**Coverage Level Selected** ☐ Employee ☐ Employee + Sp ☐ Employee + Ch ☐ Family	☐ Waive	☐ No Change
Dental	☐ Employee ☐ Employee + Sp ☐ Employee + Ch ☐ Family		☐ Waive	☐ No Change
Vision	☐ Employee ☐ Employee + Sp ☐ Employee + Ch ☐ Family		☐ Waive	☐ No Change
Voluntary life	Self $_____ Spouse $_____ Child(ren) $ *please note, an Evidence of Insurability form is required		☐ Waive	☐ No Change
Supplemental	☐ Critical Illness ☐ Accident ☐ Identify Theft		☐ Waive	☐ No Change
FSA/HSA	☐ Medical FSA ☐ Dependent Care FSA ☐ Commuter FSA ☐ HSA Annual contribution: $_____ per year		☐ Waive	☐ No Change

Spouse/Dependent Information (specific to requested addition or removal):

Name	Relationship	Gender	Date of Birth	Soc. Security Number	Add/Drop Coverage
					☐ Add ☐ Drop
					☐ Add ☐ Drop
					☐ Add ☐ Drop
					☐ Add ☐ Drop

_____ _____
Employee Signature **Date**