KALAMAZOO VALLEY COMMUNITY COLLEGE

QUALIFYING EVENT FORM

We must receive this form and required documentation within 30 calendar days of the event.

IRS rules dictate that employees enrolled in the medical, dental, vision, and flexible spending accounts cannot enroll in or change enrollment options during the plan year except during an open enrollment period, or in the event of a "change in status" life event. Employees are encouraged to provide documentation prior to 30 days and, except as noted below, under no circumstance will a change be permitted to the employee's benefits during the plan year beyond 30 days of the life event.

Employee Name (please print): ________________________ Effective Date:____________________

Valley #: _____________________________ Date of Qualifying Event: ______________________

Section I - Changes for these events are effective the date of event:

☐ Birth, Adoption or Placement for Adoption – *Provide documentation of birth date or copy of the adoption agreement or pre-adoptive placement agreement.*
Date of Birth ______________(copy of Birth Certificate)
Date of Adoption or Placement for Adoption__________(copy of adoption agreement or pre-adoptive placement agreement)

Add Dependent to: ☐ Medical/Vision ☐ Dental

Dependent Name	Social Security Number	Birth Date	Gender
____________________	_______________	__________	______

Section II - Removal of ineligible dependents is effective at the end of the month in which dependents become ineligible:

☐ Divorce – Copy of final divorce decree must be attached.
Provide address of former spouse: __________________________
____

☐ Child no longer eligible dependent: date of 26th birthday ________________

☐ Death of spouse or dependent– Provide documentation of date of death.

Section III - Changes are effective the date the life event took place:

☐ Marriage – *Copy of marriage certificate must be attached.*
☐ Custody or guardianship – *Attach copy of custody orde*r.
☐ Change in eligibility for Medicare, Medicaid or other government sponsored health care *
Your enrollment/change request must be submitted within 60 days for loss or gain of this coverage.
☐ Change of dependent's employment status *
Benefit Eligibility Change Date: __________________________
☐ Significant change in dependent's employer provided coverage *
(*NOTE: This event is not a qualifying event for Health Care Flexible Spending Account changes.)*
☐ Dependent's employer has a different Open Enrollment period and Plan Year*
Date of coverage change on Spouse's employer-provided plan: ______________________
(NOTE: This event is not a qualifying event for Health Care Flexible Spending Account changes.)
☐ Loss of coverage due to: ____

Add Remove o: ☐ Medical/Vision ☐ Dental

Dependent Name	Spouse	Child	Social Security Number	Birth Date	Gender
________________________	☐	☐	_______________	__________	______
________________________	☐	☐	_______________	__________	______
________________________	☐	☐	_______________	__________	______

* See page 2 for documentation needed for each event

HR Use Only	Received By	Medical	Dental	Vision	FSA
Initial/Date					

Important – Read carefully before signing
This is to certify that I incurred the family status change checked above, and therefore, wish to change my plan benefits as indicated on the enrollment/change form(s) attached. I understand that the change requested must be consistent with the family status change event and the effective date of the change to the coverage will be as indicated above. I further understand that documentation of status change must be received by the Human Resources department no later than 30 days from the date of the life event or no later than 60 days if due to loss or gain of government coverage. I elect to participate in the Benefits Plan and I authorize the College to reduce my compensation by the amount required to pay my share of the premiums for the coverage that I have elected.

Employee Signature: ____ **Date:**________________

Qualifying Events

Additional Documentation

Qualifying Event	Documentation Needed
Change in eligibility for Medicare, Medicaid or other government sponsored health care	HIPAA Certificate from former plan **OR** Letter on prior employer's/government entities letterhead stating: • Date letter is prepared • Name of employer/government entity that provided coverage • Name of employee/dependents losing coverage • Date coverage ends • Name of prior carrier
Change of dependent's employment status	HIPAA Certificate from former plan **OR** Letter on employer's letterhead stating: • Date letter is prepared • Name of employee and covered dependents • Name of employer providing coverage • Date coverage ended (if adding spouse/dependents to Court coverage) OR Date coverage will begin (if dropping spouse/dependents from Court coverage) • Name of carrier • Employer contact name, phone number, address
Dependent's Employer's Open Enrollment and Benefits Plan Year is different from KVCC	Letter on spouse's employer's letterhead stating: • Date letter is prepared • Name of Spouse's employer • Name of Spouse/dependents changing coverage • Date coverage change is effective • Employer contact name, phone number, address
Loss of coverage	HIPAA Certificate from former plan **OR** Letter on prior employer's letterhead stating: • Date letter is prepared • Name of employer that provided coverage • Name of employee/dependents losing coverage • Date coverage ends • Name of prior carrier • Employer contact name, phone number, address