



Form must be submitted within
30 days of event
*See Important Timelines for
details on the back page

MAJOR LIFE EVENT FORM

Last Name

First Name

Employee ID Number

Home Phone Number

Work Phone Number

Effective Date

Step 1: Reason for Change (See back for details) – Please check the appropriate option

- | | |
|--|--|
| <input type="checkbox"/> Change in employment/coverage
<input type="checkbox"/> You <input type="checkbox"/> Your Spouse/DP <input type="checkbox"/> Your Child(ren)
<input type="checkbox"/> Birth, adoption, custody of child
<input type="checkbox"/> Marriage/Registered Domestic Partnership
<input type="checkbox"/> Divorce (or legal separation) | <input type="checkbox"/> Unpaid Leave
<input type="checkbox"/> Return from Leave
<input type="checkbox"/> Loss of dependent status
<input type="checkbox"/> Death
<input type="checkbox"/> Court Order |
|--|--|

Step 2: Enter covered dependents that are being added or removed

Name	Relationship	Date of Birth	Sex	Social Security#	Medical		Dental		Vision		Life Ins.*	
					Add	Remove	Add	Remove	Add	Remove	Add	Remove
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you are electing the medical or dental HMO, please write in your primary care physician (PCP).

Step 3: Choose Plan(s)

- Core PPO Medical
- Value EPO Medical
- Signature HMO Medical
- High Deductible HDHP Medical
- PPO Dental
- HMO Dental
- High Vision
- Low Vision
- Life Insurance **(*Application Required)**

Step 4: Choose Level

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family
- Domestic Partner or Child
- Domestic Partner and Child

Step 5: Provide documentation

- County Issued Marriage Certificate
- Birth Certificate(s) for children
- Proof of Domestic Partnership
- Divorce or legal separation Decree
- Certificate of Group Health Coverage
- Court Order
- Death Certificate

Step 6: Elect Annual Contribution Amount(s)

- Flexible Spending Account (FSA) _____
- Dependent Care Spending Account (DFSA) _____
- Health Savings Account (HSA) _____
- Limited Purpose Flexible Spending Account _____

My signature certifies that the information provided is true and correct.

Signature

Date

Changing Your Coverage

Once you elect coverage, you generally cannot change your elections until the following open enrollment period. However, there are certain circumstances when you may be eligible to change your coverage earlier. A change in status is one of the following:

- You marry, divorce, or register a domestic partner
- Your spouse or other covered dependent dies
- Your child is born or adopted
- Your spouse or registered domestic partner begins or ends employment
- You, your spouse, or registered domestic partner change from full-time to part-time employment, or vice versa, where eligibility changes
- You, your spouse, or registered domestic partner take an unpaid leave of absence or return from leave
- There is a significant change in the health coverage provided to you through your spouse's employer, or registered domestic partner's employer

Important Timelines: If you have a change in status that includes a **marriage, death, birth, or spouse's, or registered domestic partner's employment beginning or ending, you must notify Human Resources within 30 days of when the change occurs.** If you have a change in status that includes a **divorce, legal separation, gain/loss of a state-funded health plan (such as Medi-Cal or Healthy Families) or loss of dependent status, you must notify Human Resources within 60 day of when the change occurs.** You will then be able to make appropriate changes to your elections including adding or dropping coverage, or changing your level of coverage (you only, you plus spouse, you plus child(ren) or you plus family). PLEASE NOTE: You cannot change plans, such as changing from the HMO to the PPO.

The coverage change you make must be consistent with your change in status. For example, if you are covered and get married during the year, you may add your new spouse to your plan. Or, you may drop your Community Medical Centers medical plan coverage if you'll be covered under your spouse's employer-provided medical plan.

Documentation Requirements – examples include:

- County Issued Marriage certificate
- County Issued Birth Certificate
- Proof of Registered Domestic Partnership
- Death certificate
- Divorce decree
- Certificate of Group Health Coverage showing termination of benefits
- Letter from spouse's or registered domestic partner's employer on company letterhead showing change in benefits

All coverage changes will be effective on the first day of the first month following the submission date of your major life even form (except for the birth of a child, marriage or death of a dependent, which will be effective the date of the event). Human Resources must receive the major life event form and acceptable documentation within 30 days before or after the event date.

For more information, contact Human Resources, Benefits Department at (559) 459-1919 or email at HRBenefits@communitymedical.org. You may also fax to (559) 724-4332.