

HEALTH INSURANCE QUALIFYING STATUS CHANGE FORM

EMPLOYEE NAME (Last, First) _____

EMPLOYEE NUMBER OR SSN _____

CONTACT INFORMATION (E-Mail, Telephone, FAX, OR Mailing Address) _____

Section 1: Qualifying Change in Status

What is your qualifying event? _____ Date of Event: _____

What proof of the event are you providing? _____

Section 2: Enroll In or Change Coverage

If you are enrolling for coverage because of a loss of coverage elsewhere or if you are changing your option because of a qualifying change in residence, you must complete and attach an enrollment form.

Section 3: Change in Dependents You Are Covering

Complete this section if you are adding or canceling coverage for any of your dependents. If you are adding dependents, you must provide proof of their eligibility. As a reminder, non-disabled dependent children are eligible for medical to age 19 (23 if full-time students) and for dental to age 19.

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SEX	SSN	MEDICAL COVERAGE	DENTAL COVERAGE
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Add <input type="checkbox"/> Cancel

If you are eligible for FLES, a rate option that is available only when both spouses are employed by the State of Connecticut, eligible for health insurance, and enrolled in the same plan, along with at least one child, complete the following information about your spouse:

Name: _____ Employing Agency: _____ Employee ID Number: _____

Section 4: Change Authorization

I certify that all information on this form is correct to the best of my knowledge and belief, and understand that providing false and/or incomplete information may result in rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s).

Employee Signature: _____ Date: _____

HR USE ONLY:	EFFECTIVE DATE:	DATE ENTERED:	INITIALS:
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