Please be aware when experiencing a family status change, you may only increase or decrease your existing tier of coverage. You can only enroll in new coverage if your Family Status Change relates to loss of coverage in which you can provide substantial proof. All family status changes must be made within 30 days of the life event. Please refer to the section below to assist you in determining supporting documents required and the type of change(s) you are allowed to make.

**Marriage**
- Copy of marriage certificate required and proof of joint debt
- Add new spouse and dependents to your current medical, dental, vision, and life plans
- Start coverage for your spouse under your current life insurance up to the guarantee issue amount

**Divorce**
- Copy of Final court filed divorce decree required for change
- Remove ex-spouse from all plans

**Birth/Adoption of dependent**
- Copy of Confirmation of Birth or Record of Birth on hospital letterhead required for change (SSN is not required)
- Add a newborn to your current medical, dental, vision, and life plans

**Loss of dependent’s eligibility (new coverage)**
- Medical coverage can only be dropped for a dependent if they have proof of new coverage

**Loss of coverage - employee only or family**
- Must provide proof of benefits termination date and dependents covered (if applicable) for change
- You can only enroll in the plan(s) you lost and provide proof of new coverage for the coverage you lost

Continued on next page...

**Enrolled in new coverage outside of Georgia Tech**
- Must provide proof and effective date of new coverage for change

**Important:** Letters from employers, judges, attorneys, hospitals, or doctors must be on authorized letterhead or stationery of the person or company verifying the change.
Please fill out the information below before proceeding to the next pages in this package.

<table>
<thead>
<tr>
<th>Last Name, Middle Initial, First Name</th>
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<th>Social Security Number</th>
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<th>Department</th>
<th>Title</th>
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**Reason for Change**

- □ Marriage
- □ Divorce
- □ Death
- □ Newborn Child
- □ Legal Custody of a parent
- □ Dependent child married/reached age limit
- □ Add coverage for myself
- □ Increase/decrease life/disability benefits
- □ Adoption/Legal custody of a child
- □ Unpaid Leave
- □ Other insurance
- □ Other _______________

**Date of Family Status Change**

Please continue to the next pages to enter dependent information, additional benefit information, and authorize your changes.
# FAMILY STATUS CHANGES FORM

## Medical
- **Comprehensive Care**
- **Consumer Choice HSA**
- **Kaiser Permanente HMO**
- **BlueChoice HMO**
  - Employee PCP required, ID#: ______________________
  - Waive Medical Coverage

**Employee Supplemental Life w/ AD&D (x Salary)**
- 1x
- 2x
- 3x
- 4x
- 5x
- 6x
- 7x
- 8x
  - Waive Supplemental Life Coverage

**Spouse Life**
- Guaranteed up to $50,000: ______________________
- Waive Spousal Life Coverage

**Child(ren) Life**
- Enroll: ______________________
- Waive Child(ren) Life Coverage

*You must complete medical questions if your election exceeds 3X salary or $500,000.

## Dental
- **Delta Dental Base PPO**
- **Delta Dental High PPO**
- **Delta Dental HMO**
  - Waive Dental Coverage
  - Delta Dental Facility HMO ID#: ______________________

## Vision
- **Employee Only**
- **Employee + Spouse**
- **Employee + Child(ren)**
- **Family**
  - Waive Vision Coverage

## USG Voluntary AD&D
**Employee Plan**
- Enroll: $___________
- Family Plan: Spouse 40% + Child(ren) 10%; Spouse only 50%; Child only 15% (percentage amounts are of the employee AD&D amount)

**Spouse**
- Enroll: $___________

**Child(ren)**
- Enroll: $___________

*You must complete medical questions if your election exceeds 3X salary or $500,000.

## Flexible Spending Account (FSA)
- **Health Care FSA**
  - 3Annual Contribution: $___________
  - Waive Health Care FSA

- **Dependent Care FSA**
  - 3Annual Contribution: $___________
  - Waive Dependent Care FSA

- **USG Hospital Indemnity**
  - Enroll: $___________

**USG Voluntary AD&D**
- Waive

**USG Accident**
- Waive

**USG Identity Theft**
- Waive

**USG Legal**
- Waive

**USG Hospital Indemnity**
- Waive

**Health Savings Account (HSA) & LP HSA**
- Must be enrolled in the HSA POS medical plan to participate in these savings accounts.

- **3HSA Annual Contribution**: $___________
  - (Not including GT matching contribution)

- **LP HSA Annual Contribution**: $___________

- Waive Health Care FSA

3Annual contribution is divided over remaining paychecks for the calendar year.
Employee Name: ______________________  SSN: ____________

FAMILY STATUS CHANGES FORM

**Dependent Information**

<table>
<thead>
<tr>
<th>Add/Drop</th>
<th>Last name</th>
<th>First Name</th>
<th>M.I.</th>
<th>SSN (required)</th>
<th>DOB</th>
<th>Gender</th>
<th>Medical</th>
<th>Dental</th>
<th>Vision</th>
<th>Tobacco</th>
<th>BlueChoice HMO</th>
<th>Supporting Documents</th>
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**Tobacco Surcharge**

A tobacco user is defined as any employee who is currently using tobacco products. “Tobacco products” include but are not limited to cigarettes, cigars and chewing tobacco. This election can only be changed if you certify that you have stopped using tobacco products.

Check one:  □ I am currently a tobacco user  □ I am not a tobacco user

____________________________________  ____________________
Signature  Date

**Acknowledgment & Authorization of Benefits**

I have read and understood the following statements with regard to my health, dental and vision plan elections.

1. Network physicians, dentists, other healthcare professionals, facilities and agencies are subject to change during the plan year. To find out if your healthcare providers participate in the network, please contact the insurance carrier directly.

2. I authorize the adjustment of my annual taxable salary based on my elections, with the pre-tax funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year unless I experience a qualified change in status and have submitted documentation of this change within 30 days of the event. I further understand this form must be signed and dated prior to my plan effective date to be eligible to participate this plan year. Any unused amounts remaining in my account at the end of the plan year will be forfeited. However, I will have 90 days after the end of the plan year or date of my termination to submit receipts for reimbursement for services received during the plan year or coverage period.

3. Any dependents I am enrolling meet the eligibility requirements described in the benefit enrollment materials and/or plan documents. I understand, I must furnish a copy of my marriage license, divorce decree, adoption papers, birth certificate, court order establishing guardianship and/or any additional documentation required. Making false statements about meeting the eligibility requirements, failing to notify the Institute of loss of eligibility within 30 days of such loss, or failing to provide documentation when requested will lead to de-enrollment of the family member(s) and possible appropriate legal action. In addition, employees may be subject to disciplinary action and will be responsible for any employer contributions to and any additional costs paid by the Institute.

I authorize deductions, if appropriate, for my benefit choices based on the current rate and any future rate changes. Deductions will be taken on a pre-tax or post-tax basis according to the Georgia Tech, Section 125 form.

____________________________________  ____________________
Signature  Date