FAMILY STATUS CHANGES

Qualifying Events

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.

FAMILY STATUS CHANGES

Qualifying Events

Please fill out the information below before proceeding to the next pages in this package.

Last Name, Middle Initial, First Name	
Social Security Number	**Phone Number**
Department	**Title**

Reason for Change

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

Date of Family Status Change

Please continue to the next pages to enter dependent information, additional benefit information, and authorize your changes.

Georgia Tech

FAMILY STATUS CHANGES FORM

Revised 02/20/2017

Name (First, Middle Initial, Last)	Social Security Number	Department/Title	Contact Phone Number

Medical

- ☐ Comprehensive Care[1]
- ☐ Consumer Choice HSA[1,2]
- ☐ Kaiser Permanente HMO
- ☐ BlueChoice HMO[1]
  Employee PCP required, ID#: _ _ _ _ _ _ _ _ - _ _ _
- ☐ Waive Medical Coverage

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family

[1]This plan is administered by BlueCross BlueShield of Ga. and uses the POS network. [2]Not eligible for J Exchange Visitor Program.

Dental

- ☐ Delta Dental Base PPO
- ☐ Delta Dental High PPO
- ☐ Delta Dental HMO
- ☐ Waive Dental Coverage

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family

Delta Dental Facility HMO ID#: _____

Vision

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

Employee Supplemental Life w/ AD&D (x Salary)

☐1x ☐ 2x ☐ 3x ☐ 4x* ☐ 5x* ☐6x* ☐7x* ☐ 8x*

☐ Waive Supplemental Life Coverage

Spouse Life (Increments of $10,000 up to $500,000)

☐ Guaranteed up to $50,000: $_____

☐ Waive Spousal Life Coverage

Child(ren) Life (Increments of $5,000 up to $15,000)

☐ Enroll: $_____

☐ Waive Child(ren) Life Coverage

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

USG Voluntary AD&D

Employee Plan
(Increments of $10,000 up to $500,000)

☐ 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: $_____

USG Accident

☐ Waive

USG Critical Illness

☐ Waive

Identity Theft

☐ Waive

Spouse
☐ Waive

USG Legal

☐ Waive

Lifestyle Benefits

☐ Waive

USG Hospital Indemnity

☐ Waive

Flexible Spending Account (FSA)

Health Care FSA

- ☐ [3]Annual Contribution: $_____
- ☐ Waive Health Care FSA

Dependent Care FSA

- ☐ [3]Annual Contribution: $_____
- ☐ Waive Dependent Care FSA

Health Savings Account (HSA) & LP HSA

Must be enrolled in the HSA POS medical plan to participate in these savings accounts.

- ☐ [3]HSA Annual Contribution: $_____
  (Not including GT matching contribution)
- ☐ LP HSA Annual Contribution: $_____
- ☐ Waive Health Care FSA

[3]Annual contribution is divided over remaining paychecks for the calendar year.

Employee Name: _____ **FAMILY STATUS CHANGES FORM** SSN: _____

Revised 02/20/2017

Dependent Information

Add/Drop	Last name	First Name	M.I.	SSN (required)	DOB	Gender	Medical (select coverage with an X)	Dental	Vision	Supporting Documents	Tobacco User	BlueChoice HMO Physician ID #

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