Family Status Change Form

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 needed and the type of change(s) you are allowed to make.

Marriage

- Copy of marriage certificate required
- 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 (age 19-26 no longer a full time student, graduates, or gets married, new coverage)

- Medical coverage can only be dropped for a dependent if they have proof of marriage or new coverage
- Must provide proof of graduation or marriage for dependent age 19-26 to drop dental, vision, and life 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.

Georgia Tech

Employee Name: _____

Family Status Change Form

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

Personal Information:

Last Name:	Middle Initial:
First Name:	
Social Security Number:	
Department:	Title:
Phone Number:	

Reason for Change:

Marriage: ☐

Death: ☐

Unpaid Leave: ☐

Newborn Child: ☐

Divorce: ☐

Retiree Change: ☐

Other Insurance: ☐

Adoption/legal custody of child: ☐

Dependent child married/reached age limit: ☐

Legal custody of parent: ☐

Add coverage for myself: ☐

Increase/decreases life or disability benefits: ☐

Date of Family Status Change:

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

Georgia Tech

Employee Name: _____

Family Status Change Form

Add Dependent Coverage:

Fill out the section below if you are adding coverage for a dependent.

Last Name	First Name	M.I.	SSN	Date of Birth	Gender	Relationship	Medical	Dental	Vision	Life	Full-time Student	BlueChoice HMO ID#
							☐	☐	☐	☐	☐	
							☐	☐	☐	☐	☐	
							☐	☐	☐	☐	☐	
							☐	☐	☐	☐	☐	

Delete Dependent Coverage:

Fill out the section below if you are canceling coverage for a dependent.

Last Name	First Name	M.I.	SSN	Date of Birth	Gender	Relationship	Medical	Dental	Vision	Life
							☐	☐	☐	☐
							☐	☐	☐	☐
							☐	☐	☐	☐
							☐	☐	☐	☐

2014 New Hire Benefits Enrollment Form

New Hire Start Date: _____
Benefits Election 30-Day Deadline: _____
Retirement Election 60-Day Deadline: _____

PERSONAL INFORMATION

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

MEDICAL, DENTAL, AND VISION

Medical

- ☐ Open Access POS[1] — ☐ Employee Only
- ☐ HSA Open Access POS[1,2] — ☐ Employee + Spouse
- ☐ Kaiser Permanente HMO — ☐ Employee + Child
- ☐ BlueChoice HMO[1] (PCP required) — ☐ Family

Employee PCP ID#: __ __ __ __ __ __ __ __ - __ __ __

☐ **Waive Medical Coverage**

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

Dental

- ☐ Delta Dental Base PPO — ☐ Employee Only
- ☐ Delta Dental High PPO — ☐ Employee + Spouse
- ☐ Delta Dental HMO — ☐ Employee + Child(ren)
- ☐ **Waive Dental Coverage** — ☐ Family

Delta HMO Facility ID# _____

Vision

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

USG LIFE INSURANCE—Additional forms needed for enrollment and beneficiary designations (visit http://www.ohr.gatech.edu/benefits/Forms#Life)

Employee Supplemental Life w/AD&D Coverage (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**

*Guaranteed up to the lesser of 3x salary or $500,000. 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)

☐ $ _____

"Family Plan- Spouse 40% + Child(ren) 10%; Spouse only 50% ; Child only 15% (% are of the employee AD&D amount)

Spouse/Domestic Partner

☐ $ _____

Child(ren)

☐ $ _____

Disability (MetLife)

Short Term Disability (STD)

☐ Enroll

☐ **Waive STD Coverage**

Long Term Disability (LTD)

☐ Enroll

☐ **Waive LTD Coverage**

ADDITIONAL BENEFITS

Identity Theft Protection

Legal Club of America

☐ Enroll

☐ **Waive Coverage**

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 FSA

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

☐ [3]HSA Annual Contrib.: $_____
(Not including the GT matching contribution)

☐ LP FSA Annual Contrib.: $_____

☐ **Waive Health Care HSA**

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

Legal Services

☐ ARAG

☐ **Waive Legal Coverage**

Georgia Tech

Employee Name: _____

Family Status Change Form

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:** _____

Acknowledgement & 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 that 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:** _____