

# EMPLOYEE STATEMENT OF QUALIFYING EVENT

## Instructions

- Locate your qualifying change in event & complete entire applicable section
- Pay close attention to the "SC" Code located in the right hand column
- Complete the Employee Certification Box with your signature & date
- Attach to your *Personal Benefit Election Change Request Form*

## QUALIFYING EVENTS

<input type="checkbox"/>	<b>1. Marriage</b>	SC 1.1.1
I was married as of (date) _____		
Spouse Name: _____ SSN _____		
<hr/>		
<input type="checkbox"/>	<b>2. Lost Spouse</b>	SC 1.1.2
I lost a spouse as of (date) _____		
Reason: <input type="checkbox"/> Divorce <input type="checkbox"/> Legal Separation <input type="checkbox"/> Annulment <input type="checkbox"/> Death of Spouse		
Spouse Name: _____ SSN _____		
<hr/>		
<input type="checkbox"/>	<b>3. Gained Dependent</b>	SC 1.2.1
I have gained the dependent(s) listed below as of (date) _____		
Dependent Name(s): _____		
Reason: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Legal Guardianship		
<hr/>		
<input type="checkbox"/>	<b>4. Lost Dependent</b>	SC 1.2.2
I have lost the dependent(s) listed below as of (date) _____		
Dependent Name(s): _____		
Reason: <input type="checkbox"/> Death <input type="checkbox"/> Placement for Adoption		
<hr/>		
<input type="checkbox"/>	<b>5. Employee Gained Eligibility Through Change In Employment</b>	SC 1.3.1
I have gained eligibility under the Plan through a change in employment as of (date): _____		
Change: <input type="checkbox"/> Part-Time to Full-Time <input type="checkbox"/> Hourly to Salary <input type="checkbox"/> Back from Strike/Lockout		
<input type="checkbox"/> Rehired after 30 days of termination <input type="checkbox"/> Return from non-FMLA Leave after 30 days		
<input type="checkbox"/> Other event: (describe): _____		
Newly Eligible Benefits: <input type="checkbox"/> All under Plan <input type="checkbox"/> Specific Component(s) _____		
_____		

## Employee Certification

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer: Erskine College

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**6. Spouse/Dependent Gained Eligibility under their Employer's Plan through Change in Employment** SC 1.3.5  
My spouse or dependent has gained eligibility under their employer's Plan through a change in employment as of (date): \_\_\_\_\_.  
Newly Eligible Benefit(s):  All under Plan  Specific Component(s) \_\_\_\_\_  
Benefits Elected as a result: \_\_\_\_\_ as of (date) \_\_\_\_\_  
Name of  Spouse  Dependent \_\_\_\_\_  
Change: \_\_\_\_\_  Hired  Part-Time to Full-Time  Hourly to Salary  Back from Strike/Lockout  
 Other event: (describe): \_\_\_\_\_

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**7. Spouse/Dependent Lost Eligibility under their Employer's Plan through Change in Employment** SC 1.3.6  
My spouse or dependent has lost eligibility under their employer's Plan through a change in employment as of (date) \_\_\_\_\_.  
Lost Benefit(s):  All under Plan  Specific Component(s) \_\_\_\_\_  
Benefits Dropped as a result: \_\_\_\_\_ as of (date) \_\_\_\_\_  
Name of  Spouse  Dependent \_\_\_\_\_  
Change:  Terminated  Full-Time to Part-Time  Salary to Hourly  Go on Strike/Lockout  
 Other event: (describe): \_\_\_\_\_

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**8. Dependent Gains Eligibility under Employee's Plan** SC 1.4.1  
My dependent has become eligible for my plan or one of its components as of (date) \_\_\_\_\_  
Dependent Name: \_\_\_\_\_  
Newly Eligible Benefit(s):  All under Plan  Specific Component(s) \_\_\_\_\_  
Reason for Eligibility:  Attains Specified Age  Becomes Single  Becomes Student  
 Other event: (describe): \_\_\_\_\_

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**9. Dependent Loses Eligibility under Employee's Plan** SC 1.4.2  
My dependent is no longer eligible for my Plan or one of its components effective as of (date) \_\_\_\_\_  
Dependent Name: \_\_\_\_\_  
Lost Benefit(s):  All under Plan  Specific Component(s) \_\_\_\_\_  
Reason for Ineligibility:  Attains Specified Age  Gets Married  Ceases to be a student  
 Other event: (describe): \_\_\_\_\_

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**10. Employee Gained Eligibility for Plan Component through Change of Residence** SC 1.5.1  
A change in my residence has made me eligible one of Plan's components effective as of (date) \_\_\_\_\_.  
New Address: \_\_\_\_\_  
Newly Eligible Component(s): \_\_\_\_\_

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**11. Employee Lost Eligibility for Plan Component through Change of Residence** SC 1.5.2  
A change in my residence has made me ineligible for one Plan's components effective \_\_\_\_\_.  
New Address: \_\_\_\_\_  
Newly Ineligible Component: \_\_\_\_\_

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**Employee Certification**

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer: Erskine College

**12. Employee moves out of HMO Service Area** SC 1.5.3  
I moved out of my HMO Service Area as of (date) \_\_\_\_\_ .

**13. Spouse/Dependent Gained Eligibility for Plan Component through Change of Residence** SC 1.5.4  
A change in my spouse's or dependent's residence has made them eligible for one of the components of my Plan effective as of (date) \_\_\_\_\_  
New Address: \_\_\_\_\_  
 Spouse  Dependent Name: \_\_\_\_\_  
Newly Eligible Component(s): \_\_\_\_\_  
Election Resulting from Change: \_\_\_\_\_

**14. Spouse/Dependent Lost Eligibility for Plan Component through Change of Residence** SC 1.5.5  
A change in my spouse's or dependent's residence has made them ineligible for one of the components of my Plan effective as of (date) \_\_\_\_\_  
New Address: \_\_\_\_\_  
 Spouse  Dependent Name: \_\_\_\_\_  
Component(s) Dropped as a Result: \_\_\_\_\_

**15. Day Care Provider Changed Rates** SC 2.1.3  
The Day Care Provider for my child has changed rates as of (date): \_\_\_\_\_  
Dependent Name: \_\_\_\_\_  
Name of Day Care Provider: \_\_\_\_\_  
Day Care Provider is  my relative  is not my relative.  
Old Rates: \_\_\_\_\_ New Rates: \_\_\_\_\_

**16. Individually Owned Policy Changed Rates** SC 2.1.3  
My Individually Owned Policy has changed rates as of (date): \_\_\_\_\_  
Policy Carrier Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Policy Type: \_\_\_\_\_  
Old Rates: \_\_\_\_\_ New Rates: \_\_\_\_\_

**17. Employee Response to Significant Cost Increase** SC 3.1.1b  
I understand my elected benefit \_\_\_\_\_  
has had a significant cost increase.  
 I understand that \_\_\_\_\_  
has been categorized, as a similar coverage, and I would like to replace my current election with it.  
 I understand that there is no similar coverage, so I would like to drop my current election.

**18. Employee Response to Significant Cost Decrease** SC 3.2.1b  
I understand that the (benefit) \_\_\_\_\_  
has had a significant cost decrease.  
 I would like to replace my current election of (benefit) \_\_\_\_\_ and elect the above benefit.  
 I would like to add the above benefit.

**Employee Certification**

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer: Erskine College

**19. Employee Response to Significant Coverage Curtailment (without loss of coverage)** SC 4.1.1b  
I understand the coverage under my elected benefit \_\_\_\_\_  
has been significantly curtailed, but is not considered to be a loss of coverage.  
 I understand that \_\_\_\_\_ has been categorized as a similar coverage, and I would like to replace  
my current election with it..

**20. Employee Response to Significant Coverage Curtailment that is considered a loss of coverage** SC 4.1.1c  
I understand the coverage under my elected benefit \_\_\_\_\_ has been significantly curtailed  
and is considered to be a loss of coverage  
 I understand that \_\_\_\_\_ has  
been categorized as a similar coverage, and I would like to replace my current election with it.  
 I understand that there is no similar coverage, so I would like to drop my current election.

**21. New Day Care Provider for Employee's Dependent** SC 5.1.5  
I have changed Day Care Providers for my child as of (date): \_\_\_\_\_  
Previous Day Care Provider: \_\_\_\_\_  
New Day Care Provider: \_\_\_\_\_  
Old Rates: \_\_\_\_\_ New Rates: \_\_\_\_\_

**22. Day Care Provider for Employee's Dependent has changed rates.** SC 5.1.6  
The Day Care Provider has changed rates effective (date): \_\_\_\_\_  
The Day Care Provider is not a relative.  
Old Rates \_\_\_\_\_ New Rates: \_\_\_\_\_

**23. Coverage has been Increased Under Another Employer Plan** SC 6.1.1  
Coverage under (plan) \_\_\_\_\_  
For (type of benefit) \_\_\_\_\_  
Has been increased for  myself,  my spouse and/or  my dependent(s) effective as of (date) \_\_\_\_\_  
Dependent Names: (if applicable) \_\_\_\_\_

**24. Coverage has been Decreased Under Another Employer Plan** SC 6.1.2  
Coverage under (plan) \_\_\_\_\_  
For (type of benefit) \_\_\_\_\_  
Has been decreased for  myself,  spouse and/or  dependent(s) effective as of (date) \_\_\_\_\_  
Dependent Names: (if applicable) \_\_\_\_\_

**25. Eligibility for Coverage has been Gained Under Another Employer Plan** SC 6.1.1  
Eligibility has been gained (and benefit elected) under (plan) \_\_\_\_\_  
For (type of benefit) \_\_\_\_\_  
Coverage under that benefit will start for  myself,  my spouse and/or  my dependent(s) effective (date) \_\_\_\_\_  
Dependent Names: (if applicable) \_\_\_\_\_

**26. Eligibility for Coverage has been Lost Under Another Employer Plan** SC 6.1.2  
Eligibility has been lost (and benefit dropped) under (plan) \_\_\_\_\_  
For (type of benefit): \_\_\_\_\_  
Coverage under that benefit will stop for  myself,  my spouse and/or  my dependent(s) effective (date) \_\_\_\_\_  
Dependent Names: (If applicable) \_\_\_\_\_

**Employee Certification**

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer: Erskine College

**27. Spouse or Dependent Dropped/Decreased Elections under Their Cafeteria Plan during Open Enrollment** SC 6.1.3  
My  spouse  dependent changed elections under their cafeteria plan during open enrollment effective (date) \_\_\_\_\_ .  
The following benefits were dropped or decreased:  
Benefit: \_\_\_\_\_  Dropped  Decreased  
Benefit: \_\_\_\_\_  Dropped  Decreased  
Benefit: \_\_\_\_\_  Dropped  Decreased

**28. Spouse or Dependent Added/Increased Elections under Their Cafeteria Plan during Open Enrollment** SC 6.1.3  
My  spouse  dependent changed elections under their cafeteria plan during open enrollment effective (date) \_\_\_\_\_ .  
The following benefits were dropped or decreased:  
Benefit: \_\_\_\_\_  Added  Increased  
Benefit: \_\_\_\_\_  Added  Increased  
Benefit: \_\_\_\_\_  Added  Increased

**29. Employee Lost Coverage under Group Health Plan of a Governmental or Educational Institution** SC 6.1.4  
I lost coverage under (Plan) \_\_\_\_\_ effective as of (date) \_\_\_\_\_  
 Spouse  Dependent Name \_\_\_\_\_

**30. Spouse/Dependent Lost Coverage under Group Health Plan of a Governmental or Educational Institution** SC 6.1.4  
My spouse/dependent lost coverage under (Plan) \_\_\_\_\_ effective as of (date) \_\_\_\_\_  
Remember to complete the **Benefit Payment Options while on FMLA** form.

**31. Beginning FMLA Leave** SC 7.1.1  
I am going on FMLA effective \_\_\_\_\_  
Remember to complete the **Benefit Payment Options while on FMLA** form.

**32. Returning from FMLA Leave** SC 7.2.1  
I am returning from FMLA effective \_\_\_\_\_  
This notification only needs to be submitted if the employee revoked elections during the FMLA and wishes to reinstate the elections.

**33. COBRA** SC 8.1.1  
I have experienced a COBRA event for a benefit elected under Cafeteria Plan, and I remain an eligible participant in this Cafeteria Plan..  
COBRA Event: \_\_\_\_\_ Effective as of (date): \_\_\_\_\_  
Benefit: \_\_\_\_\_

**34. COBRA** SC 8.1.2  
My spouse/dependent has experienced a COBRA event for a benefit I have elected under my cafeteria plan.  
Name of  Spouse  Dependent: \_\_\_\_\_  
COBRA Event: \_\_\_\_\_  
Benefit: \_\_\_\_\_

**35. Judgment, Decree, or Order Requiring Employee to Provide Coverage for Dependent** SC 9.1.2  
I have a Judgment, Decree, or Order requiring someone to provide coverage for my Dependent(s) .  
Name of Dependent(s): \_\_\_\_\_  
Coverage Required: \_\_\_\_\_  
Coverage was provided as of (date): \_\_\_\_\_

**Employee Certification**

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer: Erskine College

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**36. Judgment, Decree, or Order Requiring Another Person to Provide Coverage for Dependent** SC 9.1.2  
I have a Judgment, Decree, or Order requiring someone else to provide coverage for my Dependent(s) effective as of (date)\_\_\_\_.  
Name of Dependent(s): \_\_\_\_\_  
Coverage Required: \_\_\_\_\_  
Coverage Effective as of (date): \_\_\_\_\_

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**37. Employee Attained Eligibility for Medicare or Medicaid** SC 10.1.1  
I have become eligible for  Medicare  Medicaid (other than coverage for pediatric vaccines).  
My coverage is effective as of (date) \_\_\_\_\_.

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**38. Spouse/Dependent Attained Eligibility for Medicare or Medicaid** SC 10.1.2  
My spouse or dependent(s) has become eligible for  Medicare and  Medicaid (other than coverage for pediatric vaccines).  
The coverage is effective as of (date) \_\_\_\_\_  
 Spouse  Dependent Name: \_\_\_\_\_

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**39. Employee Lost Eligibility for Medicare or Medicaid** SC 10.2.1  
I have lost my eligibility for  Medicare and  Medicaid (other than coverage for pediatric vaccines) effective as of (date) \_\_\_\_\_.

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**40. Spouse/Dependent Lost Eligibility for Medicare or Medicaid** SC 10.2.2  
My spouse or dependent(s) has lost their eligibility for  Medicare and  Medicaid (other than coverage for pediatric vaccines) effective as of (date) \_\_\_\_\_.  
 Spouse  Dependent Name: \_\_\_\_\_

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***Employee Certification***

I certify that I have incurred the above listed qualifying event and if requested, will provide the proper documentation.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer: Erskine College