# Benefit Status Changes

## Instructions For Submitting A Change

At the beginning of every new plan year (or when you are first hired), you make an irrevocable election of your benefits for the plan year. **In order to make a new election in your benefits coverage during the plan year, change forms must be submitted within 31 days of an allowable "status change" as determined under the IRS regulations and the S.125 Flexible Benefits Plan document**. If changes are not made within 31 days, you will have to wait until the next Open Enrollment.

**NOTE:** Mid-year election changes will only be allowed if your change request is **consistent** with the change in status. This rule applies to the following County benefit plans:

Medical Insurance

Dental Insurance

Vision Insurance

Basic Life Insurance

Voluntary Accidental Death & Dismemberment Insurance

Flexible Spending Accounts

Aflac

### Adding or Removing Dependents

When adding or removing a dependent because they have lost or gained coverage through their employer, another parent, etc., you must provide proof of the actual date the coverage is effective or terminating. Examples of proof are verification from the employer on company letterhead or an ID card with a date the coverage began.

### Premiums Due for new Dependents

An employee adding a dependent on the medical insurance may need to provide a personal check to Human Resources for any "arrears" premiums. Arrears payments may occur if the employee's share of the premium increases and the dependent is added after the month's premium has already been payroll deducted. Dependents will not be added to the coverage until arrangements for the arrears payments are made.

**Medical Insurance:** When you enroll a new baby or a new spouse within 31 days of the birth or marriage, then the coverage is effective on the birth date or marriage date. The County uses a 1st of the month rule for both newborns and new spouses to determine when the premium is changed for the new dependent. If the baby is born or if the marriage date is the 1st of the month, then you MUST pay premiums for that month. (*Example:* Born or married on May 1st, the premium increases on May 1st.) If the baby is born or if the marriage date is after the 1st, then you do NOT pay an increased premium for that month, even though the effective date is the same as the birth or marriage date. (*Example:* Born or married on May 2nd, the coverage begins on May 2nd, but the premium doesn't increase until June 1st.)

**Dental, Vision, Life Insurance:** If you enroll a new dependent within 31 days of the status change, depending upon the situation, the request might be able to be processed in the next month available so no arrears payment will be due. Check with Human Resources to determine if premium arrears payments will be required.

**Forms Needed:**

- Complete the Flexible Benefits Change in Status Form
- Attach proof of the status change (ie., letter from employer, divorce decree, etc. – See Below).
- Complete the insurance change form (medical, dental, vision, etc.)., as appropriate.
- Forward completed forms to Human Resources for approval.

## REQUIRED DOCUMENTATION FOR MOST FREQUENT STATUS CHANGES

| Type of Status Change | Effective Date | Documentation Needed |
|---|---|---|
| Marriage | Date of the marriage | Copy of marriage license |
| Divorce | Last day of the month that the divorce became final | Copy of first page and signature page of divorce decree (signed and dated by the judge) |
| Birth | Date of the birth | None |
| Spouse gains or loses eligibility through another group sponsored plan | Either the first day of the month, or the first day of the following month. Employee's choice – may owe arrears if choosing the first of the month in which the status change occurred. | Letter on company letterhead stating the date the benefits become effective or are termed, what benefits are entailed, and family members affected or HIPAA Certificate of Creditable Coverage. |
| Death of a Spouse | Date of death | N/A. If questions, contact Human Resources |
| Adoption or Legal Guardianship | Date placed in custody | Adoption: Document from adoption agency placing child in custody.<br>Legal Guardianship: court document granting guardianship |
| Part-Time to Full-Time change in employment status for employee or spouse | First of month coincident with or following change in status | Spouse: Letter on company letterhead stating the date the benefits become effective, what benefits are entailed, and family members affected. |
| Full-Time to Part-Time change in employment status for employee or spouse | First of month coincident with or following change in status | Spouse: Letter on company letterhead stating the date the benefits are termed, what benefits are entailed, and family members affected. |

**PLEASE NOTE: Forms will not be accepted unless all required documentation is attached. Please make a copy of all forms for your own records.**

**LARIMER COUNTY**
**FLEXIBLE BENEFITS PLAN – "CHANGE IN STATUS" FORM**

Employee Name:_____ SSN:_____

Department:_____ Work Phone:_____

## INSTRUCTIONS:

Check the appropriate box to indicate a Change in Status or a Change in Cost or Coverage that may qualify you to change your coverage or FSA election for the Plan Year.

**Date of Change of Status:**_____

**CHANGES IN STATUS:**

**Change in Marital Status:** ☐ Marriage ☐ Divorce ☐ Death of Spouse ☐ Legal Separation

**Change in Number of Dependents:** ☐ Birth ☐ Death ☐ Adoption ☐ Legal Guardianship

| **Change in Employment Status:** | **You** | **Spouse/Dependent** |
|---|---|---|
| Termination of Employment: | ☐ | ☐ |
| Part-Time to Full-Time: | ☐ | ☐ |
| Full-Time to Part-Time: | ☐ | ☐ |
| Commencement of Employment/Benefits: | ☐ | ☐ |
| Commencements of Unpaid Leave of Absence: | ☐ | ☐ |
| Return from Unpaid Leave of Absence: | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |

**Change in Dependent's Eligibility:**
Loses Eligibility: ☐ Age 26

**CHANGES IN COST OR COVERAGE:** (Note: Changes in cost or coverage do not allow for changes to the Medical FSA.)

- Significant Cost Increase and/or Reduction of Your or Your Dependent's Coverage ..... ☐
- Addition or Elimination of Benefit Package Under Your or Your Dependent's Employer's Plan ..... ☐
- Change in Coverage or Open Enrollment of Spouse or Dependent Under Other Employer's Plan ..... ☐

## INSURANCE PLANS

↳ Complete the appropriate insurance forms to change your benefit elections.

## FLEXIBLE SPENDING ACCOUNTS (FSA)

☐ I do not wish to participate.
☐ No Change
☐ **Health Care Flexible Spending Account:** Plan Year (annual) Contribution: $_____
***Maximum:*** $2,600 per plan year
☐ **Dependent Daycare Flexible Spending Account:** Plan Year (annual) Contribution: $_____
***Maximum:*** $2,500 per plan year if you are married and filing tax return separately from spouse.
$5,000 per plan year if you are single, head of household, or married and filing jointly.

## I UNDERSTAND:

1. I may be required to provide the appropriate documentation for any of the changes I have checked above. The status and participation changes must comply with Larimer County's plan and the Human Resources Department has sole discretion to make the determination.
2. The payroll change will be effective on the date below and will be figured from the effective date of the status change.
3. **The requested change in the benefit election must be consistent with the status change and will be deemed consistent only if the change is necessary or appropriate as a result of the status change.
4. This request must be submitted within 31 days of the status change.

Employee Signature:_____ Date:_____

**HR Use Only:**
☐ Approved ☐ Denied Reason:_____ Event Date:_____
Coverage Date:_____

# LARIMER COUNTY INSURANCES CHANGE FORM

*Medical, Dental, and Vision Insurance Changes*

## A. EMPLOYEE INFORMATION

| Last Name | First Name | Marital Status: ☐Single ☐ Married | MI | Social Security Number | Birth Date |
|---|---|---|---|---|---|
| Street Address | City | State | Zip | Home Phone | Work Phone |

## B. CHANGES DESIRED

☐ **Add Dependents**

☐ **Cancel Coverage** (check all that apply): ☐ Medical ☐ Dental ☐ Vision

☐ **Remove Dependents:** *COBRA ELIGIBILITY*: If the change is due to one of the following, please provide a mailing address on the line below *for the affected dependents*: 1) divorce or legal separation, or 2) dropping a child that is no longer eligible because they have reached age 26.

## C. CHECK DESIRED COVERAGE

**Medical:** ☐ Standard PPO ☐ Choice PPO ☐ Decline Coverage
☐ Employee Only ☐ Employee + Spouse ☐ Employee + 1 Child ☐ Employee + Children ☐ Employee + Family

**Dental:** ☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family ☐ Decline Coverage

**Vision:** ☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + Family ☐ Decline Coverage

## D. DEPENDENT ENROLLMENT INFORMATION

| Last Name, First Name, MI | SSN Required | Relationship | Birth Date | M/F | Check if Disabled? | Check One: Add | Check One: Delete | Insurances: Medical | Insurances: Dental | Insurances: Vision |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## E. SIGNATURE SECTION

I agree to be bound by all terms of the plan under which I am applying for coverage. This authorization applies as long as I have coverage under the plan. I agree that a copy of this authorization shall be as valid as the original. I certify that, to the best of my knowledge, the information shown on this form is correct. I understand that if I do not enroll either myself or my dependent(s) when first eligible, then I may have to wait until the next Open Enrollment period to enroll. I may also apply for coverage within 31 days of a loss of other coverage. I hereby authorize the deduction(s) of the appropriate premium(s) for the coverage(s) listed above.

Employee Signature _____ Date _____

**HR USE Only:**
Approved By:_____ Effective Date:_____