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
- Flexible Spending Accounts
- VOYA Supplemental Insurances

PREMIUMS DUE FOR ARREARS COVERAGE

An employee adding a dependent or spouse 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 or spouse is added after the month's premium has already been payroll deducted. Dependents and/or spouse 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 or spouse. 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.)

FORMS NEEDED:

- Complete the Benefit Status Change (LCHR-052) Form
- Attach proof of the status change (ie., letter from employer, divorce decree, etc. – see next page).
- 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 certificate.
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).
Child or Spouse gains or loses eligibilty through another group sponsored plan	Either the first day of the month, or the first day of the following month. Employee choice - may owe arrears if choosing the first of the month in which the status change occurred.	Letter or benefits statement 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 or Child	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. Legal Guardianship: Court document granting guardianship.
Part-Time to Full-Time Change in employment status for employee, spouse or child.	First of month coinciding with or following change in status.	Letter or benefits statement on company letterhead stating the date the benefits became effective, what benefits are entailed, and family members affected.
Full-Time to Part-Time Change in employment status for employee, spouse, or child.	First of month coinciding with, or following change in status.	Letter or benefits statement on company letterhead stating the date the benefits became effective, 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 "BENEFIT STATUS CHANGE" FORM

A. EMPLOYEE INFORMATION

Last Name:	First Name:	MI	Marital Status:	Social Security Number:	Birth Date:
			☐ Single ☐ Married		

Street Address:	City	State	Zip	Home Phone:	Work Phone:

B. CHANGES IN STATUS

Date of Change of Status:_____

Change in Marital Status:	Change in Number of Dependents:
☐ Marriage ☐ Divorce ☐ Death of Spouse ☐ Legal Separation	☐ Birth ☐ Death ☐ Adoption ☐ Legal Guardianship

Change in Employment Status: ☐ You ☐ Spouse ☐ Child

☐ Termination of Employment ☐ Part-time to Full-time ☐ Full-time to Part-time ☐ Commencement of Employment/Benefits
☐ Commencement of Unpaid Leave of Absence ☐ Return from Unpaid Leave of Absence ☐ Other:_____

Changes in Cost or Coverage: *(Note: Changes in cost or coverage do not allow for changes for the Medical FSA.)*

☐ Please check if there is a significant cost increase or reduction in yours or your dependent's coverage; addition or elimination of a benefit package under yours or your dependent's employer's plan; change in coverage or Open Enrollment of spouse or dependent under other employer's plan.

C. CHECK DESIRED COVERAGE

Medical Insurance					Dental Insurance	Vision Insurance
Insurance Plan: ☐ Standard PPO ☐ Choice PPO ☐ HDHP ☐ Decline Coverage					☐ Employee Only	☐ Employee Only
Insurance Coverage:					☐ Employee + 1 Dependent	☐ Employee + 1 Dependent
☐ Employee Only	☐ Employee + Spouse	☐ Employee + 1 Child	☐ Employee + Children	☐ Employee + Family	☐ Employee + Family	☐ Employee + Family
					☐ Decline Coverage	☐ Decline Coverage

Dependent Enrollment Information

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

☐ I agree to be bound by all terms of the plan under which I'm 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 coverages listed above.

D. FLEXIBLE SPENDING ACCOUNTS (FSA)

☐ No Change ☐ I do not wish to participate.

Health Care Flexible Spending Account *Maximum: $2,700 per plan year*	Dependent Daycare Flexible Spending Account *Maximum: $2,500 or $5,000 depending on tax filing status.*
☐ Plan Year (Annual) Contribution: $_____ Per Paycheck (24) Amount: $_____	☐ Plan Year (Annual) Contribution: $_____ Per Paycheck (24) Amount: $_____

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 by:_____ Effective Date:_____