Department Use Only:

Life Status Change Form

You MUST attach this completed form and proof of the life status change to a completed Employee Benefit Enrollment/Change Form

Employee Name (Last, First) *Please print*	Banner ID	Access ID	Date of Birth

Street Address	City	State	Zip

Date of Hire	Work Phone	Home Phone	Email

This form, in conjunction with a completed Employee Benefit Enrollment/Change Form, is used to notify the Total Compensation and Wellness Department of Life Status Changes as described below. Be sure to check the "Life Status Change" box on the Employee Benefit Enrollment/Change Form.

You can change the level of coverage under your medical/vision/dental/life plans during the year only if you experience a change in your family status. The Internal Revenue Code defines a Life Status Change as:

- Marriage, divorce, or other eligible person
- Birth or adoption of a child
- Death of a dependent
- Change in employment status of you or your spouse resulting in loss or gain of coverage
- Change in eligibility status of your dependent child
- Judgment, decree or order
- Medicare entitlement

Internal Revenue Code Section 125 requires that your benefit change must be consistent with the Life Status Change. Your Life Status Change MUST be reported within 30 DAYS of the event. Your new election will be effective the first of the month. The addition of a child due to birth, adoption, or marriage will be effective as of the date of birth, adoption, or marriage if the Life Status Change is reported within 30 days. Marriages and other eligible people will be effective as of the date of marriage or successfully meeting OEP requirements. If you fail to report a Life Status Change within 30 days of the event, you cannot make any changes in your coverage until the next annual Open Enrollment or next qualifying event.

You must also provide proof of the Life Status Change such as a proof of new coverage, a letter from a previous employer indicating termination of coverage, a copy of the birth certificate for the birth of a child, etc. This form along with supporting documentation must be submitted within 30 days of the event.

Description of Event (Select one of the above descriptions):____

Date of Event:____

Authorization: I understand that falsely certifying eligibility requirements in any respect could result in disciplinary action, that the University may request additional eligibility evidence, that I will be liable for all expenditures for coverage and benefits plus any administrative expenditure and that I must notify the Total Compensation and Wellness Department immediately when a dependent becomes ineligible.

I certify that the information provided is true and correct. I authorize the University to change my benefit enrollments and to adjust my payroll deduction in accordance with the changes I have requested.

Employee Signature	Date

Please return to: Total Compensation and Wellness, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637