Life Status Change/Benefit Plan Termination Form

Submit Within 30 days of the life status change

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

Security Alert: Do not send this form via E-mail

Employee Name (Last, First) *Please print*	Banner ID	Social Security No.	Date of Birth

Street Address	City	State	Zip

Date of Hire	Work Phone	Home Phone	Email/Access ID

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

- ☐ 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
- ☐ Unpaid Leave of Absence

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 or adoption will be effective as of the date of birth or adoption 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 when reported prior to the life event. 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, marriage certificate, etc. This form along with supporting documentation must be submitted within 30 days of the event. The required supporting documentation must be sent along with this form.

Description of Event: (check one of the above descriptions)
Date of Event:

Use the table below for terminations. If enrolling a dependent in coverage, skip this section and submit a Benefit/Enrollment Change Form

Last Name	First Name	Social Security Number (Required)	DOB (M/D/Y)	Relation Code*	Reason for Termination of Coverage
(Self)					

*Relation Code: S=Employee, M=Spouse, C=Child, R=Senior Rider, O=Sponsored Dependent, H=Disabled Dependent, O=Other Eligible Person

Office Use Only: ( ) SCOV ( ) BCOV ( ) SELG

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 HR Service Center 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: HR Service Center, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637, Email: askhr@wayne.edu

http://hr.wayne.edu

2019 Plan Year