Life Status/Open Enrollment Change Form

Employee Name (Last, First) Please print | Banner ID | Email/Access ID | Date of Birth

Work Phone | Home Phone

Please check one: ☐ Open Enrollment Change ☐ Life Status Change Event

Please read the following information carefully:

If you experience a qualifying Life Status Change Event as listed below, you are allowed to make certain changes to your benefits. Generally, changes to enrollment are interlocking, meaning changes are applied to all active plans (medical, vision, and/or dental). A Life Status Change Event is the only time that you are allowed to make a benefit change outside of the annual Open Enrollment period. When adding a dependent, coverage will begin the first of the month following the event date or on the date of birth or adoption. When terminating a dependent, coverage will end the last day of the month following the event date. For further Life Status Change Event information: hr.wayne.edu/tcw/health-welfare/section125-changes.pdf

This form must be received with required Dependent Supporting Documentation by the HR Service Center within 30 days of the qualifying Life Status Change Event or during the Open Enrollment period. For terminations during Open Enrollment, Dependent Supporting Documentation is not required. Dependent Supporting Documentation requirements are online: hr.wayne.edu/tcw/health-welfare/dependent-supporting-documentation.pdf

If you are not currently enrolled in a medical, vision or dental plan and/or you are changing plans due to a Life Status Change Event, you must complete this form and the *Employee Benefit Enrollment Form*.

Qualifying Life Status Change Event (*Check one*):

- ☐ Marriage or Other Eligible Person
- ☐ Divorce or Legal Separation
- ☐ Birth, adoption or placement for adoption of a child
- ☐ Judgement, decree or court order
- ☐ Medicare entitlement
- ☐ Death of a dependent
- ☐ Involuntary loss of other group benefits coverage
- ☐ Change in employment status
- ☐ Change in eligibility status of dependent child
- ☐ Unpaid Leave of Absence
- ☐ Other

Date of Event: _____

Check One: ☐ **Add Coverage** ☐ **Terminate Coverage**

Dependent Information: (only include information for individuals to be added or terminated from existing coverage)

Last Name	First Name	Social Security Number (Required)	DOB (M/D/Y)	Relation Code*	HMO must complete: Primary Care Physician Name & ID #	Office Use Only
(Self)				S		

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

☐ **I have attached the required supporting documentation**. **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

Attach required documentation and return to:
HR Service Center, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637; E-mail: askhr@wayne.edu. Use your WSU E-mail and include "#SECURE" in the subject line to ensure your personal information is encrypted.