

Charles County Government Qualifying Event Form FY14

The Human Resources Department must receive this form, your enrollment form, and documentation within 31 calendar days of the event.
Benefit changes must be on account of and consistent with the event.

Employee Name (please print): _____

SSN: XXX-XX-____ Day Phone #: _____ Date of Event: _____

Please indicate your qualifying event:

Marriage – *Copy of marriage certificate must be attached*
_____ Opposite Sex Marriage
_____ Same Sex Marriage (*Affidavit for Spousal Eligibility and Tax Status must also be attached*)

Divorce – *Copy of final divorce decree must be attached*
Provide address of former spouse: _____

Birth of child – *provide documentation of birth and SSN upon receipt (no later than 60 days)*

Adoption, custody or guardianship – *Copy of custody paper must be attached*

Death – *Copy of death certificate must be attached*

Change in your employment status (*part-time to full-time, full-time to part-time, unpaid leave*)

Change of Spouse's employment status – *See attached page for documentation needed*
Date eligible for CCG plan: _____
Date lost eligibility for CCG plan: _____

Significant change in spouse's employer coverage –
See attached page for documentation needed
(*Note: This event is not a qualifying event for Health Care FSAs*)

Spouse's Open Enrollment - *See attached page for documentation needed*
Effective date of change: _____
(*Note: This event is not a qualifying event for Health Care FSAs*)

Loss of coverage due to: _____
See attached page for documentation needed

Child no longer eligible (reached age 26 or is eligible for health/dental insurance through their own employer)

Election of Supplemental Life Insurance

Other _____

Employee Signature: _____ Date: _____

Changes for birth, adoption, death and marriage are effective the date of the event. Other mid-year changes will be effective the first of the month following date of the event.

Primary/Contingent Beneficiary Information

Name: _____ Date: _____
 (Please Print)

Basic Life (1.5 times your salary), Accidental Death & Dismemberment Insurance and Supplemental Life Insurance (if applicable) Beneficiary

Beneficiary Name	Beneficiary SSN	Beneficiary Address	Beneficiary Date of Birth	Relationship	Primary? Y/N	Contingent? Y/N	Percentage Allocation

Pension Beneficiary

Beneficiary Name	Beneficiary SSN	Beneficiary Address	Beneficiary Date of Birth	Relationship	Primary? Y/N	Contingent? Y/N	Percentage Allocation

Payroll Beneficiary

Beneficiary Name	Beneficiary SSN	Beneficiary Address	Beneficiary Date of Birth	Relationship	Primary? Y/N	Contingent? Y/N	Percentage Allocation

Percentage Allocations of all beneficiaries (Primary and Contingent) must equal 100%. This means that your Primary beneficiaries must equal 100% and your Contingent beneficiaries must equal 100%.

Employee Signature: _____ Date: _____

Qualifying Events Documentation

Qualifying Event	Documentation Needed
Change of spouse's employment status	<p>HIPAA Certificate from former plan OR Letter on employer's letterhead stating:</p> <ul style="list-style-type: none"> • Date prepared • Name of employee and covered dependents • Name of employer providing coverage • Date coverage ended (if adding spouse/dependents to county coverage) <p style="text-align: center;">OR</p> <p>Date coverage will begin (if dropping spouse/dependents from county coverage)</p> <ul style="list-style-type: none"> • Name of carrier • Employer contact name, phone number, address
Significant change in spouse's employer coverage	<p>Letter on spouse's employer's letterhead stating:</p> <ul style="list-style-type: none"> • Date prepared • Name of employer providing coverage • Name of employee and covered dependents • Name of current carrier • Description of significant change in coverage • Effective date of significant change in coverage • Employer contact name, phone number, address
Spouse's Open Enrollment - Benefits Plan Year is different from the County's	<p>Letter on spouse's employer's letterhead stating:</p> <ul style="list-style-type: none"> • Date letter is prepared • Name of Spouse's employer • Name of Spouse/dependents changing coverage • Date coverage change is effective • Employer contact name, phone number, address
Loss of Coverage	<p>HIPAA Certificate from former plan OR Letter on prior employer's letterhead stating:</p> <ul style="list-style-type: none"> • Date letter is prepared • Name of employer that provided coverage • Name of employee/dependents losing coverage • Date coverage ends • Name of prior carrier • Employer contact name, phone number, address

Letters may be addressed and sent to the employee, OR FAX to:
Charles County Human Resources Department Benefits Division,
Phone 301-645-0585 FAX: 301-396-8862

Qualifying Event Form, Enrollment Form(s), and documentation **MUST** be received in the Human Resources Benefits Division **within 31 days of the qualifying event.**