Qualifying Event Status Change Form

Pinellas County employees who need to make a change in benefits must submit this form, along with documentation supporting the reason for the change, to Employee Benefits ***no later than 31 days from the date of the qualifying event.*** See reverse for documentation requirements and signature box.

PERSONAL INFORMATION			
Last Name	First Name	Middle Initial	Phone
Mailing Address		Apt. Number	Employee ID
City	State	Zip Code	Social Security Number
Department	Coverage Effective Date		Premium Effective Date

I AM CHANGING *(select all that apply)*

- ☐ Medical Plan
- ☐ Dental Plan
- ☐ Flexible Spending Account
- ☐ Add/Remove Dependent(s) from coverage
- ☐ Supplemental or Dependent Life Insurance coverage
- ☐ Group Term Life Beneficiary/ies*

I AM CANCELLING *(select all that apply)*

- ☐ Medical Plan
- ☐ Dental Plan
- ☐ Flexible Spending Account(s)
- ☐ Long-term Disability
- ☐ Supplemental Life Insurance
- ☐ Dependent Life Insurance

NEW OR UPDATED PLAN COVERAGE *(select all that apply)*

HEALTH PLAN	Health Coverage Level	DENTAL PLAN	Dental Coverage Level
☐ Point of Service (POS)	☐ Employee	☐ PPO Dental	☐ Employee
☐ Consumer Driven with HSA	☐ Employee + Spouse	☐ HMO Dental	☐ Employee + 1
☐ Opt Out (affidavit required)	☐ Employee + Child(ren)	☐ Decline	☐ Employee + 2 or more
☐ Decline	☐ Family		

Tobacco Use

- ☐ I have used tobacco, defined as cigarettes, e-cigarettes, cigars, pipes, chewing tobacco, dip, snuff or hookahs at least once a week in the past three months.
- ☐ I have NOT used tobacco, defined as cigarettes, e-cigarettes, cigars, pipes, chewing tobacco, dip, snuff or hookahs at least once a week in the past three months, OR, I completed a tobacco cessation program between August 1, 2020 and April 30, 2021.

ADD OR REMOVE DEPENDENTS FROM COVERAGE

Health	Dental	Last Name	First Name	MI	Relationship	Gender M	Gender F	Date of Birth	Social Security #	Add	Remove
						☐	☐			☐	☐
						☐	☐			☐	☐
						☐	☐			☐	☐
						☐	☐			☐	☐

FLEXIBLE SPENDING ACCOUNTS (FSA) Your annual contribution amount will be divided by the remaining pay periods during the year.

New Healthcare FSA annual amount $_____ New Dependent Care FSA annual amount $_____

LIFE INSURANCE All supplemental life increases require submission of an underwriting form for review and approval.

Additional/Reduced Supplemental Life Insurance amount requested: $ _____

Dependent Life: ☐ $10,000 spouse/$5,000 child(ren) ☐ $20,000 spouse/$10,000 child(ren)

* Life insurance beneficiary updates are done in OPUS: *PIN Self-Service > Benefits > Beneficiaries > Update Beneficiaries.* To name a trust, charitable organization, estate, or another beneficiary that is not a person, complete the life insurance change form at www.pinellascounty.org/hr/life and submit to Employee Benefits (see contact information on reverse).

Human Resources *Helping U Succeed*

See reverse for documentation requirements and signature box. ▼

DOCUMENTATION REQUIREMENTS FOR COVERAGE CHANGES

Your benefit elections are in effect for the calendar/plan year. The IRS allows mid-year changes to your coverage if you experience a qualifying event. The changes that are allowed must match the type of event. For example, if you get married, you can change your coverage from *Employee* to *Employee and Spouse*. See more examples:

Qualifying Event Examples	Change Allowed	Required Documentation
Birth, adoption, placement for adoption or legal guardianship	Add child to existing plan	Copy of birth certificate, court order of legal custody, or other legal documentation
Marriage or divorce	Add or remove spouse from existing plan	Copy of marriage license or divorce decree
Domestic partner relationship change	Add partner to existing plan	Affidavit and tax certification
Domestic partner relationship ends	Remove partner from existing plan	Termination Statement of Domestic Partnership
Change in employment status for you, spouse or dependent child; or gain/ lose coverage under another plan	Add or remove yourself, spouse or dependent child from existing plan	Copy of COBRA notice (for loss of coverage) Letter from employer on letterhead including name(s) of those gaining/losing coverage, date coverage begins/ends, and type of coverage gained/lost (medical and/or dental)
Death of a spouse, partner or child	Remove spouse, partner or child from existing plan	Copy of death certificate

BENEFITS ENROLLMENT ACKNOWLEDGEMENT

- The Pinellas County benefit plan documents including Summary Plan Descriptions, Summary of Benefits and Coverage, plan documents, and certificates of coverage are available on the Pinellas County website at www.pinellascounty.org/hr/benefits or by requesting hard copy documents from Employee Benefits. These documents define plan eligibility for myself and my eligible dependents, services/benefits provided by the plan, coverage termination rules and, based on plan, appeal processes. It is my responsibility to review these documents and become familiar with the provisions regarding my coverage.
- **The information provided for my elections is true and correct to the best of my knowledge.**
- Any dependents enrolled in coverage meet the eligibility requirements outlined in the Summary Plan Description, plan document or certificate of coverage for each benefit plan they are enrolled in.
- These benefit elections are effective for the remainder of the calendar/plan year January 1 through December 31 unless I have a qualifying event during the plan year that allows me to make corresponding changes to my benefit elections.
- I authorize the deductions from my earnings for any contributions for the benefit coverages selected. This includes any elections for the Healthcare or Dependent Care Flexible Spending Account or a Health Savings Account contribution.
- I understand that my supplemental life insurance premium and/or coverage amount may change during the plan year based on a change in my age or salary as described in the certificate of coverage for the life insurance plan.
- If I elect to "Opt Out of Health" insurance coverage I must submit to Employee Benefits the Pinellas County Group Health Plan Opt-Out Incentive Summary and Affidavit no later than the last day of the enrollment period.
- If I elect domestic partner coverage:
  - ✓ An affidavit and tax certification must be submitted to Employee Benefits by the last day of the enrollment period in order to enroll my domestic partner (and their eligible children) in health and/or dental coverage.
  - ✓ Premiums paid to cover my domestic partner (and their qualifying children) are made on a post-tax basis per IRS requirements. If they are not a tax dependent, the value of coverage will be added to my pay as imputed income.
  - ✓ Imputed income is the amount of the contribution Pinellas County makes for coverage for your domestic partner (and their eligible children) who are not your tax dependents as defined by the IRS. Imputed income is separate from, and in addition to, your biweekly health insurance premium and will be added to your annual W2 earnings.

SIGNATURE _____ **DATE** _____

PRINT NAME _____ **EMPLOYEE #** _____

For full plan details, refer to the plan documents posted at www.pinellascounty.org/hr/benefits.
Pinellas County Government reserves the right to change, suspend or terminate plans at any time.

Submit this completed form and your documentation by mail, fax or email:

Pinellas County Human Resources Employee Benefits, 400 South Fort Harrison Avenue, Clearwater, FL 33756
Fax: (727) 453-3573 | Email: employee.benefits@pinellascounty.org | Questions? Call (727) 464-4570
(Please do not email forms that include social security numbers. Use mail or fax instead.)