Dickinson

# LIFE STATUS CHANGE FORM

Name (Please Print) _____ Department _____ Phone Extension _____

This form and the completed appropriate Insurance Enrollment/Change form, is used to notify Human Resource Services of Life Status Changes as described below.

Life Status Change:

This portion of the form is used to notify Human Resource Services of one of the Life Status Changes which permits you to change a pre-tax benefit election. You can change the level of coverage under your medical/dental/vision during the year only if you experience a change in your family status. The Internal Revenue Service defines a Life Status Change as:

- Marriage or divorce
- Birth, adoption or legal guardian of a child
- Death of a spouse or child
- Judgment, decree or order
- Medicare entitlement
- Change in employment status of you, your spouse/same-sex domestic partner or adult dependent child resulting in loss or gain of coverage

The Internal Revenue Service requires that your benefit change must be consistent with the Life Status Change.

If your Life Status Change is reported within **31 days** of the event, your new election will be effective the first of the month following the event. 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 31 days of the birth or adoption. If you fail to report a Life Status Change within 31 days of the event, you cannot make any changes in your coverage until the next Annual Open Enrollment.

You must also provide proof of the Life Status Change such as a letter from a previous employer indicating activation or termination of coverage, a copy of marriage certificate, a copy of the birth certificate for the birth of a child or a copy of the court order for adoption or legal guardianship of a child.

Life Status Change Event: _____

Date of Life Status Change Event: _____

Authorization:

I certify that the information provided is true and correct. I authorize the College to change my benefit enrollments and to adjust my payroll deduction in accordance with the changes I have requested. Falsification of information may lead to corrective action up to and including termination of employment.

Employee Signature: _____ Date: _____

Social Security Number: _____

***TO ASSURE PROMPT ACCURATE PROCESSING OF YOUR CHANGE, BE SURE YOU ATTACH PROOF OF THE LIFE STATUS CHANGE AND RETURN TO HUMAN RESOURCE SERVICES WITH THE COMPLETED INSURANCE ENROLLMENT/CHANGE FORM.***