

FAMILY STATUS CHANGE

Natural Select

Employee Name: _____ Employee ID # _____

Indicate Qualifying Event Type: _____ (Marriage, Birth, Divorce, Significant Change in Employment – See definitions on back)

Date of Above Event: _____ (Please indicate the date the event occurred.)

You may make certain changes to your *Natural Select* choices at the time of a family status change. If you wish to do so, indicate your **new** selections below. **It is not necessary to complete this form if you are not making changes.** **All forms, including the required legal documents, must be completed and returned to the benefits unit no later than 30 days from the date of the event.**

Note: If the event indicated above results in a change to your coverage status, i.e. from 1 person to 2 person, 2 person to 3 person or more etc., your benefit credit and price tags will also be adjusted accordingly, at the time of the event.

I wish to change to the indicated coverages below:

HEALTH

- Blue Preferred Plan (PPO)
- Health Alliance Plan (HAP)
(HAP Not offered to those hired after 5/31/03)
- Comprehensive Major Medical (CMM)
- No Coverage (spouse is County employee)
- No Coverage (spouse is not County employee)

VISION

- High Plan
- Standard Plan

REIMBURSEMENT ACCOUNTS*

- Dependent Care** -
Previous Annual Amt. \$ _____
New Annual Amt. \$ _____
- Health Care** -
Previous Annual Amt. \$ _____
New Annual Amt. \$ _____

DENTAL

- High Plan
- Standard Plan
- Modified Plan
- No Coverage (spouse is County employee)
- No Coverage (spouse is County employee)

LIFE INSURANCE

- 1 X Annualized Salary
- 1/2 X Annualized Salary (Standard)
- 2 X Annualized Salary
- 3 X Annualized Salary

ACCIDENTAL DEATH

- 1 X Annualized Salary (Standard)
- 1/2 X Annualized Salary
- 2 X Annualized Salary
- 3 X Annualized Salary

*Whole dollars only. We will begin new amount indicated the first pay period following receipt of this form. In the case of birth, adoption, marriage, death or divorce, attach this form to a Membership & Record Change form. In the case of a significant change in employment, see description on back of form. In order to process the change, both forms must be returned at the same time.

I certify that the above information is true and correct.

Employee Signature _____ Date _____

OFFICE USE ONLY

Effective Date: _____ Old Status: H _____ D _____ V _____ New Status: H _____ D _____ V _____ Int. _____

Status Change-Natural Select

Permitted Actions

Event	Medical	Accidental	Life	Reimbursement	Accounts	Effective Date
	Dental Vision	Death & Dismemberment		Health Care	Dependent Care	
Marriage	Change or Drop Coverage Add Spouse & Dependents	Increase or Decrease Coverage	Increase or Decrease Coverage	Increase or Decrease Contributions	Add/Drop Increase or Decrease Contributions	Date of Event
Birth and/or Adoption	Add Coverage Add Spouse & Dependents	Increase or Decrease Coverage	Increase or Decrease Coverage	Add Coverage Increase Contributions	Add or Increase contributions	Date of Event
Divorce	Change Coverage Delete Spouse Add Dependents who lose coverage	Increase or Decrease Coverage	Increase or Decrease Coverage	Decrease Contributions	Add Coverage Drop Coverage Increase or Decrease Contributions	Date of Event
Lose Coverage Due to Spouse Employment Change	Add Coverage Add Spouse and Dependents or Change Coverage	Increase or Decrease Coverage	Increase or Decrease Coverage	Add Coverage Increase Contributions	Add/Drop Coverage Increase or Decrease Contributions	Date of Event
Begin FMLA/STD	County Continues Coverage	County Continues Coverage	County Continues Coverage	*Drop Coverage	*Drop Coverage	Date FMLA/STD Begins
Return from FMLA/STD	County Continues Coverage	County Continues Coverage	County Continues Coverage	Add/Restart Coverage	Add/Restart coverage or Increase Contributions	Date FMLA/STD Ends
Full-Time to Part-Time Eligible	Drop Coverage/ Pay to Continue Coverage	Continue PTE Coverage	Continue PTE Coverage	Not Eligible	Not Eligible	First of Month After Part-Time Begins
PTE No Coverage to Full-Time	Full Time Coverage	Full-Time Coverage	Full-Time Coverage	Add Coverage	Add Coverage	First of Month After Full-Time Begins
Leave Without Pay	Drop Coverage	Drop Coverage	Drop Coverage	Drop Coverage	Drop Coverage	**Date of Leave

***IF YOU DROP COVERAGE, BILLS MAY NOT BE SUBMITTED FOR REIMBURSEMENT FOR SERVICES INCURRED DURING THE LEAVE. IF YOU DO NOT DROP COVERAGES, BILLS MAY BE SUBMITTED BUT NOTE THAT UPON YOU RETURN THE TOTAL AMOUNT OF MISSED CONTRIBUTIONS WILL BE DEDUCTED FROM YOUR PAYCHECK OVER THE REMAINDER OF PAY PERIODS IN THE YEAR**

****UPON RETURNING FROM LEAVE WITHOUT PAY, EMPLOYEE MAY REINSTATE TERMINATED BENEFITS FOLLOWING NEW HIRE WAITING PERIOD. EMPLOYEE MUST COMPLETE AN ENROLLMENT FORM. 8/10**

Legal Documentation: Please refer to the Membership & Record change form for the required documents that MUST accompany any additions to your coverage.