



# STATUS CHANGE FORM

**We must receive this form and your Enrollment/Change form(s) within 31 calendar days of the event (60 days for some events – see below). Effective dates of coverage will be determined by the specific event as defined below.**

Employee Name (please print): \_\_\_\_\_  
SSN #: \_\_\_\_\_ Date of Event: \_\_\_\_\_

**Enrollment for these events is effective the date of event:**

**HIPAA SPECIAL ENROLLMENT**

Birth, Adoption, or Placement for Adoption – *Provide documentation of birth date, a copy of the adoption decree or pre-adoptive placement agreement, as appropriate.*

**Removal of an ineligible spouse or child is effective at the end of the month in which they become ineligible:**

**COBRA QUALIFYING EVENTS**

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

Child no longer eligible dependent (age 26)  
Provide child's address, if different: \_\_\_\_\_

Death of spouse or child - *Provide documentation of date of death.*

**Changes for the following events (addition or dropping of coverage must be consistent with the applicable event) are effective the first of the month following receipt of your request or following the event, whichever is later:**

**SECTION 125 STATUS CHANGES**

Marriage - *Copy of marriage certificate must be attached.*

Custody or guardianship – *Attach copy of custody order.*

Change in your employment status from part-time to full-time

Change in your employment status from full-time to part-time

Change in your employment status from paid status to leave without pay

Change in your employment status from leave without pay to paid status

Change in eligibility for Medicare, Medicaid or State CHIP program, including subsidy eligibility\*

Change of spouse's employment status - *See attached page for documentation needed.*  
Benefit Eligibility Change Date: \_\_\_\_\_

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

Spouse's employer has a different Open Enrollment period and Plan Year  
Date of coverage change on Spouse's employer-provided plan: \_\_\_\_\_  
*See attached page for documentation needed*  
*(Note: This event is not a qualifying event for Health Care Flexible Spending Account changes.)*

Loss of coverage due to: \_\_\_\_\_  
*See attached page for documentation needed.*

Other \_\_\_\_\_

\* Note that you have a 60-day HIPAA special enrollment period for these events.

I certify that the information above is correct and in accordance with the County of Henrico Health Plan document.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## STATUS CHANGE FORM

### Additional Documentation

*Benefit changes must be on account of and consistent with the event.*

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

### ELIGIBILITY DEFINITIONS

**Spouse** – legal marital relationship  
**Child** – natural, adopted, step, legal guardianship, legal custody, proposed adoption: under age 26 (unless Totally Disabled)

Letters may be addressed to the employee OR to:

**Henrico County Public Schools  
 Health Benefits Office  
 P.O. Box 23120  
 Henrico, VA 23223**

*Phone: 804-652-3624  
 FAX: 804-652-3988*