HONORHEALTH®

QUALIFYING EVENT FORM

(Form due within 30 days of event.
Required Documentation must be attached)

Employee Name:	Employee ID #:
Daytime phone #:	E-mail:

Qualifying Event (choose below):		**Date of event (Mandatory):**	
Proof of event is due within 30 days in order to process request			
☐ Marriage	☐ *Divorce	☐ Newborn/Adoption	☐ Loss of Child's Eligibility
☐ Employee loses Eligibility or gains other coverage	☐ Spouse/partner loses job or insurance coverage	☐ Spouse/partner becomes eligible for another plan	☐ Dependent gains coverage

Plan options:			
☐ Coordinated Care Plan ☐ Standard Plan ☐ Health Savings Account Plan (HDHP)	☐ EDS ☐ Delta Dental Basic ☐ Delta Dental Buy Up ☐ Delta Dental Enhanced	☐ United Healthcare Vision ☐ VSP, Vision Service Plan	The Hartford, Life insurance/self ☐1x ☐2x ☐3x ☐4x ☐5x Hyatt Legal: ☐

Flexible Spending Accounts (FSA):		
Healthcare Flex: $2750 Max allowed per calendar year.	☐ Yes, Amount $_____ Annual	☐ No change
Limited Purpose Flex: $2750 Max allowed per calendar year.	☐ Yes, Amount $_____ Annual	☐ No *ONLY IF IN HSA
Daycare Flex: $5000 Max allowed per calendar year.	☐ Yes, Amount $_____ Annual	☐ No change

Health Savings Account (HSA): Eligible **only** if enrolled in the Health Savings Account Medical Plan.
Employer match = Employee only /up to $20.84 per pay OR Employee plus dependent(s) / up to $41.67 per pay
Maximum contribution allowed per calendar year: Employee only = $3,600 Employee plus dependents = $7,200 (Includes match)
Age 55 or older may contribute an additional catch-up contribution of $1,000 per year.

Health Savings Account: ☐ Employee Only ☐ Employee plus dependent(s) - Amount: $ per pay period. ☐ No change

Name:		☐**M** ☐**F**	**DOB:**	**SSN#:**
☐ Add ☐ Delete	☐ Staff Member ☐ Spouse/Domestic Partner ☐ Child	☐ Medical ☐ Dental ☐ Vision	☐ Child Life ☐ $5,000 ☐ $10,000	☐ Spouse/Domestic Partner ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

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I understand that I must submit this Qualifying Event Form, proof of the qualifying event and dependent documents within **30 days** of the event to the Employee Benefits department in order for this request to be processed. I also understand that if I am adding dependent coverage, proof of dependent eligibility (i.e. Marriage license, birth certificate, domestic partner affidavit, loss of prior coverage) is required.
*If you are cancelling benefits for your spouse due to a divorce, you must provide a copy of the **full** divorce decree, and within the decree, it must address a domestic relations order with respect to your retirement savings plan.
Life insurance beneficiaries may be assigned and updated at any time throughout the year through Staff Member Self Service.
This request will **not** be processed until **all** required documentation has been received. Premiums may be doubled depending on date of submission and receipt of required documentation.

_____ _____
Employee Signature Date

Return completed form and required documents to:
Employee Benefits
Fax: 480-882-5802 or E-mail: employee.benefits@honorhealth.com