HONORHEALTH®

QUALIFYING EVENT FORM

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

Benefits Use Only: Effective Date: _____	Dep Docs /Proof of Event Rec'd: (Date/Initials): _____
Employee Name:	**Employee ID #**:
Daytime phone #:	**E-mail**:

Qualifying Event (choose below):		**Date of event (Mandatory):**	
Proof of event / dependent documents are all due within 30 days of event date to process request.			
Spouse/parent is /was HonorHealth employee: Yes ☐ No ☐		**If yes, Employee ID#:**	
☐ Marriage	☐ *Divorce/legal separation	☐ Newborn/Adoption	☐ Employee loses/gains coverage
☐ Spouse loses/gains coverage	☐ Child loses/ gains coverage	☐ SC part to full time	☐ SC full to part time

Plan options:			
☐ Coordinated Care Plan ☐ Standard Plan ☐ Health Savings Account Plan (HDHP)	☐ EDS Dental ☐ Delta Dental Basic ☐ Delta Dental Buy Up ☐ Delta Dental Enhanced	☐ United Healthcare Vision ☐ VSP, Vision Service Plan	Employee Voluntary Life Ins. ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x Annual Salary ☐ MetLife Legal

Flexible Spending Accounts (FSA):

Healthcare Flex: $3,050 Max allowed per calendar year.	☐ Yes, Amount $_____	Annual
Limited Purpose Flex*: $3,050 Max allowed per calendar year.	☐ Yes, Amount $_____	Annual *ONLY IF IN HSA
Daycare Flex: $5000 Max allowed per calendar year.	☐ Yes, Amount $_____	Annual

Health Savings Account (HSA): Eligible **ONLY** if enrolled in the Medical Health Savings Account Plan (HDHP).
Employer match = Employee only /up to $20.84 ($500 Annual) OR Employee plus dependent(s) /up to $41.67 ($1000 Annual)
Maximum contribution allowed per calendar year: Employee only = $3,850 OR Employee plus dependents = $7,750 (Includes match).
If 55 or older and interested in the catch-up please email employee.benefits@honorhealth.com

Health Savings Account: Amount: $ per pay period.

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 for this request to be processed.

**If you are canceling benefits for your spouse due to a legal separation or divorce, you must provide a copy of the full divorce decree.

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. Please allow 3-5 business days for processing.

_____ _____
Employee Signature Date

Revised 4.13.2022

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

QUALIFYING EVENT FORM CONT.

(Form due within 30 days of event.
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Employee Name:	Employee ID #:
Daytime phone#:	E-mail:

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Employee Signature Date

Revised 11.15.2022

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