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 #**:
E-mail:	**Daytime phone #:**

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.

Is/was Parent /Spouse /Child an 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) ☐ Out-of-State Plan	☐ 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: $3,300 Max allowed per calendar year.	☐ Yes, Amount $____________	Annual
Limited Purpose Flex*: $3,300 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 $20.83 ($500 Annual) OR Employee plus dependent(s) /up to $41.66 ($1000 Annual)
Maximum contribution allowed per calendar year: Employee only = $4,300 OR Employee plus dependents = $8,550 (Includes match).
If 55 or older and interested in the catch-up contribution, 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 adding dependents, proof of dependent eligibility is required. (Marriage License, if adding Spouse; Birth Certificate, if adding child /stepchild.)

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 up to 5 business days for processing.

____ ______________________
Employee Signature Date

Revised 12.20.2024

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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Daytime phone #:	E-mail:

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