

Please submit promptly by Fax to (877) 761-1850

Company/Organization: _____

Name of Employee: _____ Social Security #: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____ Effective Date: ____/____/____

1 - Indicate Action

<input type="checkbox"/> Add New Employee: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent(s)	<input type="checkbox"/> Change/Correct <input type="checkbox"/> Coverage Level <input type="checkbox"/> Elected COBRA <input type="checkbox"/> Other: _____	<input type="checkbox"/> Terminate: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent(s) <input type="checkbox"/> COBRA Coverage Terminated
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2-Qualifying Event (check all that apply)

Add Coverage – Indicate Event <input type="checkbox"/> New Hire <input type="checkbox"/> Return from Leave <input type="checkbox"/> Termination of Spouse's Employment <input type="checkbox"/> Addition of Dependent(s): <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption/Adoption Placement <input type="checkbox"/> Judgment/Decree <input type="checkbox"/> Dependent Care Rate Change (DCAP only) <input type="checkbox"/> Other: _____	Terminate Coverage – Indicate Event <input type="checkbox"/> Terminate Employment/Layoff+ <input type="checkbox"/> Employment of Spouse <input type="checkbox"/> Increase or Reduction in Hours <input type="checkbox"/> Away on Leave of Absence <input type="checkbox"/> Death of Employee <input type="checkbox"/> Retirement <input type="checkbox"/> Loss of Spouse/Dependent(s): <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Spouse/Child <input type="checkbox"/> Legal Separation <input type="checkbox"/> No Longer Legal Dependent	Terminate Coverage – Indicate Event (cont) <input type="checkbox"/> Obtained Other Coverage: <input type="checkbox"/> Enrolled in Other Group Coverage <input type="checkbox"/> Qualified for Medicare/Medicaid <input type="checkbox"/> Dependent Care Rate Change (DCAP only) <input type="checkbox"/> Other: _____
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3-Benefit(s) Affected by Qualifying Event (check all that apply)

<input type="checkbox"/> Medical FSA <input type="checkbox"/> Dependent FSA <input type="checkbox"/> Dental Insurance <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> HRA Benefits <input type="checkbox"/> Group Health Plan <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Employee + Family Name of Plan: _____	<input type="checkbox"/> Vision Insurance <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Other: _____ <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Employee + Family
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4-Participant Information – List names of ALL individuals who are affected by the qualifying event

Name	SSN	DOB	Same Address	Gender	Enrolled in Medicare?*
Employee			n/a	M / F	Y / N, If Yes, HICN
Spouse			Y / N	M / F	Y / N, If Yes, HICN
Dependent 1			Y / N	M / F	Y / N, If Yes, HICN
Dependent 2			Y / N	M / F	Y / N, If Yes, HICN
Dependent 3			Y / N	M / F	Y / N, If Yes, HICN
Dependent 4			Y / N	M / F	Y / N, If Yes, HICN

*In accordance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), ProBenefits is required to report HRA eligibility to the federal government. **Note: If Medicare enrolled individual is under age 65, please indicate if the individual is entitled to Medicare due to End-Stage Renal Disease (ESRD).**

5- Pre-Taxed Payroll Withholdings – Complete only if ProBenefits administers your FSA plan

First Payroll Date Impacted: ____ / ____ / ____ **KEY EMPLOYEE?** YES NO

Action	Type of Coverage	Payroll Frequency	Total Annual Election	EE contribution per pay period	ER contribution per pay period	Total Withholdings (Terminated EE only)
	Medical FSA		\$	\$	\$	\$
	Dependent FSA		\$	\$	\$	\$
	Health Insurance		\$	\$	\$	\$
	Dental Insurance		\$	\$	\$	\$
	Vision Insurance		\$	\$	\$	\$

Action: Enter A=Add a Coverage, C=Change a Coverage, D=Drop a Coverage

Payroll Frequency: Please indicate payroll frequency (Monthly, BiWeekly, Semi-Monthly, Weekly, 48X/yr.)

6- Current COBRA Eligible Coverages - Complete only if ProBenefits is your Cobra Administrator

Type of Coverage	Plan Name	Tier	Date Coverage Effective
Health Insurance			
Dental Insurance			
Vision Insurance			
Other			
	Total Annual Election	Total Withholding	Total Claims Paid
FSA Plan			

ARRA: Did the employee, spouse, and/or dependent(s) terminate? If so, please complete below.

This is an INVOLUNTARY Event

This is a VOLUNTARY Event

Employee rate of Pay: \$ _____ per _____

Certification By Employee

I hereby certify the above information is correct.

Date: _____

Printed Name: _____

Signature: _____

Approval by Employer Administrator

Date: _____

Printed Name: _____

Signature: _____