

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"/> <b>Add New Employee:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Dependent(s)	<input type="checkbox"/> <b>Change/Correct</b> <input type="checkbox"/> Coverage Level <input type="checkbox"/> Elected COBRA <input type="checkbox"/> Other: _____	<input type="checkbox"/> <b>Terminate:</b> <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)

<b>Add Coverage – Indicate Event</b> <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: _____	<b>Terminate Coverage – Indicate Event</b> <input type="checkbox"/> Terminate Employment/Layoff+ <input type="checkbox"/> Employment of Spouse <input type="checkbox"/> 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	<b>Terminate Coverage – Indicate Event (cont)</b> <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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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			
	<b>Total Annual Election</b>	<b>Total Withholding</b>	<b>Total Claims Paid</b>
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: \_\_\_\_\_