NCFLEX PROGRAM
2009 FAMILY/EMPLOYMENT STATUS CHANGE FORM

www.ncflex.org

Form must be completed within 30 days from the date of the event. Changes are effective the first of the month following the date of the event, with the exception of birth or adoption. Changes for a birth or adoption may be effective on the date of the event.

SECTION A: EMPLOYEE INFORMATION

Name (Last, First, MI)	Date of Birth		
Work Phone ( )	Social Security Number		
Street Address	City	State	Zip
☐ Check this box if your name or address has changed	Previous Name		

SECTION B: TYPE OF FAMILY/EMPLOYMENT STATUS CHANGE (Check one)

I incurred the family/employment status change event on the following date: ______________________________

- ☐ Marriage
- ☐ Birth or adoption of child (increase election only)
- ☐ Begin/End of spouse's employment
- ☐ Medicare/Medicaid
- ☐ Begin unpaid leave of absence (employee or spouse)
- ☐ Divorce
- ☐ Legal separation (must be living apart from spouse at least 90 days)
- ☐ From full to part-time (less than 20 hrs/week) and vice versa (employee or spouse)
- ☐ Return from unpaid leave of absence (employee or spouse)
- ☐ NC Health Choice for Children
- ☐ Termination of employee's employment or eligibility
- ☐ Ineligible dependent, due to age, marriage, or loss of full-time student status
- ☐ Significant change in health coverage due to spouse's employment
- ☐ Death of spouse/child
- ☐ Other (explain) ____
____

Benefits Representative to Complete: employment changes that do not require benefit changes:

- ☐ Transfer from agency/university/community college
- ☐ 9 – 10 month contractors

Last pay cycle for deduction: _____________ Date employee returns to work: _____________ Termination date: ______________

SECTION C: DEPENDENT CHANGE (Check all that apply)

Name (Last, First, MI)	List applicable benefits	Gender M	Gender F	Date of Birth	Full-Time Student	Handicap
SPOUSE		☐	☐	/ /	☐	☐
CHILD (1)		☐	☐	/ /	☐	☐
CHILD (2)		☐	☐	/ /	☐	☐
CHILD (3)		☐	☐	/ /	☐	☐
CHILD (4)		☐	☐	/ /	☐	☐

SECTION D: DENTAL PLAN CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ New Coverage ☐ Change Coverage Level* ☐ Cancel Coverage

Plan Option ☐ Low Option ☐ High Option

Coverage Level

☐ Employee Only ☐ Employee + One Child ☐ Family
☐ Employee + Two or more Children ☐ Employee + Spouse

*Changes are only allowed during Annual Enrollment or due to a Qualifying Event

SECTION E: VISION CARE PLAN CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ New Coverage ☐ Change Coverage Level* ☐ Cancel Coverage

Plan Option ☐ Plan 1 ☐ Plan 2 ☐ Plan 3

Coverage Level

☐ Employee Only ☐ Employee + Family

*Changes are only allowed during Annual Enrollment or due to a Qualifying Event

 Please make a copy for your records then return completed ORIGINAL form to your Benefits Representative.

FAMILY/EMPLOYMENT STATUS CHANGE FORM

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Name: ______________________________ **SSN:** ______________________

SECTION F: CRITICAL ILLNESS

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ New Coverage ☐ Change ☐ Cancel Coverage

Coverage Level

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

SECTION G: CANCER CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

You will need to submit an Evidence of Insurability Form if you are adding or increasing coverage. Visit www.ncflex.org for EOI Forms.

☐ New Coverage ☐ Change ☐ Cancel Coverage

Plan Option ☐ Low Option ☐ High Option ☐ Premium Option

Coverage Level ☐ Employee Only ☐ Employee + Family

SECTION H: ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ New Coverage ☐ Change ☐ Cancel Coverage

Plan Option

☐ Plan 1 Employee Only ☐ Plan 2 Employee & Family

Aviation Pilot/Crew Member, after you select your coverage option, check this box: ☐

Insurance Amount $________________

Beneficiary Full Name	Mailing Address (Street, City, State, Zip)	Relationship to Employee	Date of Birth	Gender M	Gender F	% of Benefit
Primary:			/ /	☐	☐	
Contingent:			/ /	☐	☐	

SECTION I: GROUP TERM LIFE CHANGE

You will need to submit an Evidence of Insurability Form if you are adding or increasing coverage. Visit www.ncflex.org for EOI Forms.

☐ New Coverage ☐ Cancel Coverage Insurance Amount $______________

☐ Change

Beneficiary Full Name	Mailing Address (Street, City, State, Zip)	Relationship to Employee	Date of Birth	Gender M	Gender F	% of Benefit
Primary:			/ /	☐	☐	
Contingent:			/ /	☐	☐	

SECTION J: FLEXIBLE SPENDING ACCOUNTS (NEW ANNUAL CONTRIBUTION AMOUNT) CHANGE

☐ Health Care FSA (**Annual** Min. $120, **Annual** Max. $4,200) **New Annual** Contribution $___________

☐ Dependent Day Care FSA (**Annual** Min. $120, **Annual** Max. $5,000) **New Annual** Contribution $___________

Your **New Annual** Contribution should equal the total amount you would like to contribute to the FSA(s) as of 12/31 of the current plan year. Per pay contributions **equal**: new annual contribution **minus** total year-to-date contributions **divided by** the pay periods remaining for the year.

☐ Cancel Health Care FSA

☐ Cancel NCFlex Convenience Card

☐ Cancel Dependent Day Care FSA

This is to certify that on the **family/employment status change event date in Section B**, I incurred the family/employment status change(s) checked in Section B, and wish to change my plan benefits as indicated on this form. I understand that the change must be consistent with the family/employment status change event and requested within 30 days of the event, and I might be required to provide documentation to my agency/university/community college benefit representative. I further understand that if my costs/contributions need to be caught up, they may be deducted from a future paycheck. **Note:** The IRS provides guidelines for the above family status changes and requires that you maintain legal documentation of the changes in your personal records. Examples of documentation include marriage, birth, or death certificates; divorce decrees; notice of legal separation; proof of change in spouse's employment; or adoption papers.

Employee Signature ________________________________ Date ____________________

Benefit Representative to Complete

Date Form Received ________________ Payroll Center #(3 digits) ______________ Prior Payroll Center #(3 digits)________________

Reviewed By ____ HBR Work Phone ____________________

 Please make a copy for your records then return completed ORIGINAL form to your Benefits Representative.