

Fax: 480-882-5802; Email: employeebenefits@shc.org

## QUALIFYING EVENT FORM BENEFIT ELECT CHANGES

Staff Member Name:		Employee #: E-mail:			
	0	ualifying E	vent C	Options	
*Marriage	☐ Newborn/Adopt		_ <i>,</i>		Loss of Childs Eligibility
Employee loses Eligibilit	<i>,</i> 1 — .	•		ouse becomes eligible	Effective Date:
or gains other coverage			for an	other plan	(HR Use only)
Other					
Name:			F	DOB:	SSN#:
Add Staff Mem	ber Tobacco User	Healt	h Plan	Child Life	Spousal Life
☐Delete ☐ *Spouse	Tobacco User	Denta	1	5,000 10,000	1 <del>- 1</del> -
Child		Vision	ı		30,000 40,000 50,000
Name		M	F	DOB:	CCVIII
Name:  Add Staff Mem	ber Tobacco User			Child Life	SSN#:  Spousal Life
☐Delete ☐ *Spouse	Tobacco User			5,000 \[ \] 10,000	1 <del>= 1</del> =
Child		Vision			30,000 40,000 50,000
		V 15101			10,000 10,000 10,000
Name:			F	DOB:	SSN#:
Add Staff Mem				Child Life	Spousal Life
☐ Delete ☐ *Spouse	☐Tobacco User			☐5,000 ☐10,000	
☐ Child		☐ Vision	ı		30,000 40,000 50,000
order for this action to take e	ffect. In addition, if I am dro	opping coverag	ge for a c	lependent after a divorce	ng event within 31 days of the event in e or a child ceasing to be a "dependent of the event in order to have the option
order for this action to take e child" under the Plan, the Empelect COBRA coverage.  I understand that if I am addin dependent to the health plan.	offect. In addition, if I am dro ployee Benefits department g dependent coverage, pro Dependent coverage will r	opping coverage must receive of of depender	ge for a c this chan nt eligibil	lependent after a divorce ge form within 60 days o ity (i.e. Marriage license,	e or a child ceasing to be a "dependent of the event in order to have the option birth certificate) is required for adding a
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Date/Initials