HCPS
Henrico County Public Schools

STATUS CHANGE FORM

We must receive this form and your Enrollment/Change form(s) within 60 calendar days after the event. Effective dates of coverage will be determined by the specific event as defined below.

Employee Name (please print): _____

SSN #:_____ Date of Event: _____

Enrollment for these events is effective the date of event: **HIPAA SPECIAL ENROLLMENT & SECTION 125 STATUS CHANGES**

☐ Birth, Adoption, or Placement for Adoption – *Provide documentation of birth date or copy of the adoption decree or pre-adoptive placement agreement.* **Request must be received in the HCPS Benefits Office within 60 calendar days after the event. Do NOT wait for the child's Social Security number. You can provide that later.**

Removal of an ineligible spouse or child is effective at the end of the month in which they become ineligible; or add coverage the first of the month following receipt of your request or following the event, whichever is later:

☐ Divorce – *Copy of final divorce decree must be attached* **COBRA QUALIFYING EVENT & SECTION 125 STATUS CHANGE**
Provide address of former spouse: _____
_____
_____

☐ Child no longer eligible dependent (age 26)
Provide child's address, if different: _____
_____
_____

☐ Death of spouse or child - *Provide documentation of date of death*. **COBRA QUALIFYING EVENT & SECTION 125 STATUS CHANGE**

Changes for the following events (addition or dropping of coverage must be consistent with applicable event) are effective the first of the month following receipt of your request or following the event, whichever is later:

☐ Marriage - *Copy of marriage certificate must be attached.* **HIPAA SPECIAL ENROLLMENT**

☐ Change in your employment status from part-time to full-time **SECTION 125 STATUS CHANGE**

☐ Change in your employment status from full-time to part-time **HIPAA SPECIAL ENROLLMENT & SECTION 125 STATUS CHANGE**

☐ Change in your employment status from paid status to leave without pay **SECTION 125 STATUS CHANGE**

☐ Change in your employment status from leave without pay to paid status **SECTION 125 STATUS CHANGE**

☐ Change in eligibility for Medicare, Medicaid, or State CHIP program, including subsidy eligibility*
*Note that you have a 60-day **HIPAA SPECIAL ENROLLMENT** for these events.

☐ Change of spouse's employment status - *See attached page for documentation needed*. **SECTION 125 STATUS CHANGE**
Benefit Eligibility Change Date:_____

☐ Significant change in spouse's employer provided coverage – See attached page for documentation needed.
(Note: This event is not a qualifying event for Health Care Flexible Spending Account changes.) **SECTION 125 STATUS CHANGES**

☐ Spouse's employer has a different Open Enrollment period and Plan Year
Date of coverage change for employer-provided plan:_____
See attached page for documentation needed
(Note: This event is not a qualifying event for Health Care Flexible Spending Account changes.)

☐ Loss of coverage due to: _____
See attached page for documentation needed.

☐ Other_____

I certify that the information above is correct and in accordance with the County of Henrico Health Plan document.;

Employee Signature:_____ Date:_____

December 2015

STATUS CHANGE FORM

Additional Documentation

Benefit changes must be on account of and consistent with the event.

Status Change	Documentation Needed
Change of spouse's employment status	Copy of HIPAA Certificate from former plan **OR** Copy of Letter on employer's letterhead stating: • Date letter is prepared • Name of employee and covered dependents • Name of employer providing coverage • Type of coverage: health or dental • Date coverage ended (if adding spouse/children to County coverage) OR Date coverage will begin (if dropping spouse/children from County coverage) • Name of carrier • Employer contact name, phone number, address
Significant change in spouse's employer-provided coverage	Copy of Letter on employer's letterhead stating: • Date prepared • Name of employer providing coverage • Name of employee and covered dependents • Type of coverage: health or dental • Name of current carrier • Description of significant change in coverage • Effective date of significant change in coverage • Employer contact name, phone number, address
Spouse's Employer's Open Enrollment and Benefits Plan Year is different from the County's	Copy of Letter on employer's letterhead stating: • Date letter is prepared • Name of employer providing coverage • Name of Spouse/children changing coverage • Type of coverage: health or dental • Date coverage change is effective • Employer contact name, phone number, address
Loss of coverage	Copy of HIPAA Certificate from former plan **OR** Copy of Letter on prior employer's letterhead stating: • Date letter is prepared • Name of employer that provided coverage • Name of employee/spouse/children losing coverage • Date coverage ends • Name of prior carrier • Employer contact name, phone number, address

ELIGIBLILITY DEFINITIONS

Spouse – legal marital relationship
Child – natural, adopted, step, legal guardianship, legal custody, proposed adoption, under age 26 (unless Totally Disabled)

Submit your completed original forms to:

Henrico County Public Schools
Health Benefits Office
P.O. Box 23120
Henrico, VA 23223
Phone: 804-652-3624
Fax: 804-652-3988