



Qualifying Event Enrollment Form

Eligibility: You have 31 days from the time of your Qualifying Event to complete this form.			
SECTION 1: Employee Information			
Last Name:		First Name:	
Social Security #:		Date of Birth:	
		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Mailing Address:		City:	State: Zip
Cell Phone:		Email:	
SECTION 2: Qualifying Event			
Special Enrollment Event Date: ___/___/___		Coverage Effective Date: ___/___/___	
<input type="checkbox"/> Newborn/Adoption <small>(Must Provide Copy of SS. Card)</small>		<input type="checkbox"/> Marital Status Change <small>(Must Provide Copy of Marriage/Divorce Cert.)</small>	
<input type="checkbox"/> Loss of Eligibility <small>(Must Provide Cert. of Creditable Cvr.)</small>		<input type="checkbox"/> Death <small>(Must Provide Copy of Death Cert.)</small>	
		<input type="checkbox"/> Gain Ins. <small>(Must Provide Proof of New Cvr.)</small>	
SECTION 3: Coverage Selection			
<input type="checkbox"/> Add Medical (MUST CHOOSE ONE) <small>TRS-HD TRS-PRIMARY TRS-PRIM + TSHB-HD TSHB-CO-PAY</small>		<input type="checkbox"/> Med Link <small>Low Option High Option (Current plan level)</small>	
		<input type="checkbox"/> Add Dental <small>Low Option High Option (Current plan level)</small>	
		<input type="checkbox"/> Add Vision	
SECTION 4: Dependent Information (Use additional page for additional dependents)			
Spouse Name:		SP SSN:	SP DOB:
Child 1 Name:		Dep SSN:	Dep DOB:
Child 2 Name:		Dep SSN:	Dep DOB:
Child 3 Name:		Dep SSN:	Dep DOB:
SECTION 5: Declination Selection			
<input type="checkbox"/> Cancel Medical		<input type="checkbox"/> Cancel MedLink	
		<input type="checkbox"/> Cancel Dental	
		<input type="checkbox"/> Cancel Vision	
Employee Name:		<input type="checkbox"/> Reason: Other Coverage	
Spouse Name:		<input type="checkbox"/> Reason: Other Coverage	
Child 1 Name:		<input type="checkbox"/> Reason: Other Coverage	
Child 2 Name:		<input type="checkbox"/> Reason: Other Coverage	
Child 3 Name:		<input type="checkbox"/> Reason: Other Coverage	

**If we don't receive required documentations within 31 days, you will have to wait until Open Enrollment to make changes to your plan.

Employee Signature: _____ Date: _____