Capital®

An Independent Licensee of the Blue Cross Blue Shield Association

QUALIFYING EVENT NOTIFICATION FORM

Group Information

Group Name:

Group ID#:

Employee Information (Please Print)

Last Name | First Name | Middle Initial

Spending Account ID

S A

Street Address

Social Security # (if SA# is not known)

City | State | Zip

Daytime Phone

Qualifying Event Information

I have experienced a change in status as indicated below. The effective date of change is: _____

(You have a limited time period to submit this change. Discuss with your benefits department to determine the time period.)

Change affects: ☐ **Self** ☐ **Spouse** ☐ **Dependent**

1. Employment Status Change

☐ Termination of employment ☐ Full-time to Part-time ☐ Leave of Absence (unpaid)
☐ Commencement of employment ☐ Part-time to Full-time
☐ Continuation through COBRA (for Medical Expense Reimbursement Only)

2. Marital Status Change

☐ Marriage ☐ Legal Separation ☐ Divorce ☐ Widowed

3. Dependent Status Change

☐ Birth ☐ Adoption ☐ Death

4. ☐ **Other:** _____

Due to the Qualifying Event indicated above, I am requesting that my Capital Blue Cross enrollment for this plan year be changed. (Election amounts cannot be lowered if your employee (self) is terminating employment)

		Current Annual Election	Current Per Pay Period Deduction Amount
From:	☐ Medical Expense	$ _____	$ _____
	☐ Dependent/Day Care Expense	$ _____	$ _____

		New Annual Election	New Per Pay Period Deduction Amount
To:	☐ Medical Expense	$ _____	$ _____
	☐ Dependent/Day Care Expense	$ _____	$ _____

Groups who submit onfile payroll information must update their onfile payroll worksheet accordingly.

Employee Signature - Not required for terminating employees (self)

I certify that the status change as noted above has occurred. I authorize that my enrollment records be changed or cancelled as requested.

Employee's Signature | Print Name | Date

Group Signature

Group Signature | Date

Questions? Call Group Leader Services at 877.293.7041.

Send via secured email only:
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