Human Resources

QUALIFIED LIFE EVENT
Benefits Enrollment

QUALIFIED LIFE EVENT FORMS MUST BE FILED NO LATER THAN 31 DAYS AFTER THE EVENT.

Prior to completing this form, please review the Summaries of Benefits and Coverage for the medical plans.

- ADOA plans
- UArizona Domestic Partner plan

For benefits rates and information about all plans, please visit https://hr.arizona.edu.

Completed and signed forms and any required supporting documentation (see p. 6) can be submitted to:

Division of Human Resources – Attn: HR Solutions
888 N. Euclid Ave., Ste. 217
Tucson, AZ 85721-0158
Phone: 520-621-3660
Box Link for Secure Document Upload: https://hr.arizona.edu/submit-documents
Label your file Employee Last Name,Employee First Name

Email: hrsolutions@arizona.edu

EMPLOYEE IDENTIFICATION INFORMATION (Print Clearly)

Last Name, First Name, M.I.	☐ Male ☐ Female	**EmplID (Required)**
Contact Phone	Email Address	

HR USE ONLY	DATE RECEIVED:	EFFECTIVE DATE:	PROCESSED BY:

PLEASE IDENTIFY THE DATE OF EVENT AND SELECT ONE BOX BELOW: _____

(Codes are for administrative purposes only)

☐ **Gain a significant other** through marriage or establishment of domestic partnership (GSO)
  ☐ Check here if your spouse was already covered on your plans as a domestic partner (COE)

☐ **Gain a child** through birth, adoption, guardianship, foster care or court order (GAC)

☐ **Loss of significant other** through divorce, legal separation, annulment, dissolution of domestic partnership (LOS)

☐ **Gained Citizenship or Residency (**Newly obtained SSN, Visa or Green Card**)** (FSC**)**

☐ **Move into or out of service area (International only) (**Employee, spouse, domestic partner or dependent child(ren)) for **90 days or longer** (FSC)

☐ **Loss of coverage** (employee, spouse, domestic partner or dependent child(ren)) through another plan (FSC). If the other plan is also through the University please provide the name of the employee who lost coverage: _____ (COE)

☐ **Gain of coverage** (employee, spouse, domestic partner or dependent child(ren)) through another plan (FSC). If the other plan is also through the University please provide the name of the employee who gained coverage: _____ (COE)

☐ **Unpaid Leave of Absence** – Please select from the boxes below and sign page 7. You do not need to complete the rest of this form unless you select "Reduce Coverage/Waiving Select Plans."

  ☐ **Decline** all benefits while on Unpaid Leave of Absence (LVT)
  ☐ **Reduce Coverage/Waive Select Plans** (LOA)
  ☐ **Reinstate** previously waived benefit plans (FSC)

DEPENDENT INFORMATION

List dependents being updated and attach supporting documentation. If you have more than six dependents or beneficiaries, please attach an additional page.

1	**Last Name, First Name, M.I.**			List Address If Different from Employee's:
	☐ **Male** ☐ **Female**	**Relationship to employee:**		**Select Plan(s) For This Dependent:**
	Birth Date	**Social Security #**	**Disabled?** ☐ Yes ☐ No	**Medical** ☐ Enroll ☐ Decline ☐ No Change **Dental** ☐ Enroll ☐ Decline ☐ No Change **Vision** ☐ Enroll ☐ Decline ☐ No Change
2	**Last Name, First Name, M.I.**			List Address If Different from Employee's:
	☐ **Male** ☐ **Female**	**Relationship to employee:**		**Select Plan(s) For This Dependent:**
	Birth Date	**Social Security #**	**Disabled?** ☐ Yes ☐ No	**Medical** ☐ Enroll ☐ Decline ☐ No Change **Dental** ☐ Enroll ☐ Decline ☐ No Change **Vision** ☐ Enroll ☐ Decline ☐ No Change
3	**Last Name, First Name, M.I.**			List Address If Different from Employee's:
	☐ **Male** ☐ **Female**	**Relationship to employee:**		**Select Plan(s) For This Dependent:**
	Birth Date	**Social Security #**	**Disabled?** ☐ Yes ☐ No	**Medical** ☐ Enroll ☐ Decline ☐ No Change **Dental** ☐ Enroll ☐ Decline ☐ No Change **Vision** ☐ Enroll ☐ Decline ☐ No Change
4	**Last Name, First Name, M.I.**			List Address If Different from Employee's:
	☐ **Male** ☐ **Female**	**Relationship to employee:**		**Select Plan(s) For This Dependent:**
	Birth Date	**Social Security #**	**Disabled?** ☐ Yes ☐ No	**Medical** ☐ Enroll ☐ Decline ☐ No Change **Dental** ☐ Enroll ☐ Decline ☐ No Change **Vision** ☐ Enroll ☐ Decline ☐ No Change
5	**Last Name, First Name, M.I.**			List Address If Different from Employee's:
	☐ **Male** ☐ **Female**	**Relationship to employee:**		**Select Plan(s) For This Dependent:**
	Birth Date	**Social Security #**	**Disabled?** ☐ Yes ☐ No	**Medical** ☐ Enroll ☐ Decline ☐ No Change **Dental** ☐ Enroll ☐ Decline ☐ No Change **Vision** ☐ Enroll ☐ Decline ☐ No Change
6	**Last Name, First Name, M.I.**			List Address If Different from Employee's:
	☐ **Male** ☐ **Female**	**Relationship to employee:**		**Select Plan(s) For This Dependent:**
	Birth Date	**Social Security #**	**Disabled?** ☐ Yes ☐ No	**Medical** ☐ Enroll ☐ Decline ☐ No Change **Dental** ☐ Enroll ☐ Decline ☐ No Change **Vision** ☐ Enroll ☐ Decline ☐ No Change

STATE-SPONSORED PLANS

These medical, dental and vision plans are **NOT** available to employees enrolling with domestic partners.
If you are enrolling in a domestic partner plan, please go to page 4.

STATE SPONSORED MEDICAL BENEFIT PLANS (Select an Action, Plan Type, Provider and Coverage Level)

Action	Plan Type	Provider	Coverage Level
☐ Enroll ☐ Decline ☐ No Change	☐ TCP	☐ Blue Cross/Blue Shield ☐ United HealthCare	☐ Employee ☐ Employee + child ☐ Employee + adult ☐ Family
	☐ HDHP w/ HSA	☐ Blue Cross/Blue Shield ☐ United HealthCare	☐ Employee ☐ Employee + child ☐ Employee + adult ☐ Family

STATE-SPONSORED DENTAL BENEFIT PLANS (Select an Action, Provider, and Coverage Level)

Action	Provider	Coverage Level
☐ Enroll ☐ Decline ☐ No Change	☐ Delta Dental PPO	☐ Employee ☐ Employee + child ☐ Employee + adult ☐ Family
	☐ United HealthCare HMO	☐ Employee ☐ Employee + child ☐ Employee + adult ☐ Family

STATE-SPONSORED VISION BENEFIT PLAN (Select an Action, Provider, and Coverage Level)

Action	Provider	Coverage Level
☐ Enroll ☐ Decline ☐ No Change	☐ Avesis	☐ Employee ☐ Employee + child ☐ Employee + adult ☐ Family

UA-SPONSORED PLANS

These UA alternative medical, dental and vision plans are ONLY available to employees enrolling domestic partners.

UA-SPONSORED MEDICAL BENEFIT PLAN (Select an Action, Plan Type, Provider and Coverage Level)

Action	Plan Type	Provider	Coverage Level
☐ Enroll ☐ Decline ☐ No Change	☐ HMO	☐ United HealthCare	☐ Employee + adult ☐ Family

UA-SPONSORED DENTAL BENEFIT PLANS (Select an Action, Provider, and Coverage Level)

Action	Provider	Coverage Level
☐ Enroll ☐ Decline ☐ No Change	☐ Delta Dental PPO	☐ Employee + adult ☐ Family

UA-SPONSORED VISION BENEFIT PLAN (Select an Action, Provider, and Coverage Level)

Action	Provider	Coverage Level
☐ Enroll ☐ Decline ☐ No Change	☐ Avesis	☐ Employee + one ☐ Family

SUPPLEMENTAL LIFE INSURANCE

You must be actively at work on the effective date of coverage.

Action	Provider	Coverage Level
☐ Enroll ☐ Decline ☐ Increase ☐ Decrease ☐ No Change	☐ Securian Supplemental Life Insurance	Increase coverage to: _____ (must be done increments of $5,000) Decrease coverage to: _____ (cannot decrease below $35,000)

Action	Provider	Coverage Level
☐ Enroll ☐ Decline ☐ Increase ☐ Decrease ☐ No Change	☐ The Hartford Supplemental Life Insurance	Increase Coverage to: ☐ 1x Salary ☐ 2x Salary ☐ 3x Salary ☐ 4x Salary ☐ 5x Salary (maximum $500,000) Decrease Coverage to: ☐ 1x Salary ☐ 2x Salary ☐ 3x Salary ☐ 4x Salary

DEPENDENT LIFE INSURANCE

You must be actively at work on the effective date of coverage.

Action	Provider	Action
☐ Enroll ☐ Decline ☐ Increase ☐ Decrease ☐ No Change	☐ Securian Dependent Life Insurance	Coverage: ☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $10,000 ☐ $12,000 ☐ $15,000 ☐ $50,000* *Minimum of $35,000 in supplemental coverage is required for employee to elect this amount for dependent.
☐ Enroll ☐ Decline ☐ No Change	☐ The Hartford Dependent Life Insurance	Coverage: ☐ $5,000

SHORT TERM DISABILITY INSURANCE

You must be actively at work on the effective date of coverage.

Action	Provider
☐ **Enroll** ☐ **Decline** ☐ **No Change**	☐ **MetLife**
	☐ **Unum Option A** (max. salary $55,714) ☐ **Unum Option B** (max. salary $111,430) ☐ **Unum Option C** (max. salary $148,571)

FLEXIBLE SPENDING ACCOUNT ELECTIONS

Please use the Flexible Spending Account Enrollment/Election Change form to make a change.

NOTICE TO PROVIDERS

The contracts between the State of Arizona and its health care plans provide that this document constitutes a valid, temporary membership card and proof of entitlement for all provider services. Failure by a provider to honor this temporary membership card may subject the provider to sanctions under its contract with the State.

DISCLAIMER

The information provided on this form is provided solely as a guide to help employees make important enrollment decisions. If there are any discrepancies between this information and official documents, official documents will always govern. The State of Arizona reserves the right to change or terminate any of its plans, in whole or part, at any time.

DECLARATION FOR PRE-TAX BENEFITS

- I authorize my employer to reduce my salary by applicable pre-tax or post-tax amounts for the benefits I have elected in this form.
- I acknowledge that I received the Summary of Benefits and Coverage documents (https://benefitoptions.az.gov/resources/summary-benefits-coverage) and that I read and understood these documents prior to making a medical election.
- I understand that I cannot change my elections until the open enrollment period unless I experience a qualifying life event and notify the University's Office of Human Resources of the change within 31 days of the event. Changes are subject to approval and must be consistent with the qualifying life event.
- I am aware that my insurance plan contributions are ineligible as deductions for income tax purposes.
- I authorize the release of this information to my insurance carriers and employer.
- I agree that, in connection with any claim for benefits I make, the University of Arizona and any of its agents or employees may disclose information or records related to my employment that may be necessary to process such claim, to the insurance carrier. I understand that this information may otherwise be protected under Arizona Board of Regents or University policies, or other laws protecting the privacy of personnel information.
- I certify under the penalty of perjury that the information I have provided in this application for employee benefits, including my address and spouse/dependent information, is true and correct. I am aware that providing false information may subject me to a denial of employee benefits, disciplinary actions, and potential prosecution under Arizona Revised Statutes Sections 13-2310, 13-2311, 13-2407, 13-2702, and other applicable law.

By my signature below, I agree to the above and authorize Human Resources to enter form information into the benefits enrollment system. I affirm that it is my responsibility to review my confirmation statement and will immediately notify Human Resources of disparities.

Printed Name: **Signature:**

Empl ID: **Date:**

REQUIRED SUPPORTING DOCUMENTATION

Please see the payroll calendar for pay period start dates: http://www.fso.arizona.edu/Payroll/ calendars.html.

Type of Event	Documentation Needed	Effective Date of Coverage
Gain Significant Other	**Marriage or Establishment of Domestic Partnership** – Copy of Marriage Certificate or Domestic Partner Certification Forms and supporting documentation. Forms are located on the HR website at http://hr.arizona.edu/forms	First day of the pay period following submission of completed forms to HR
Gain a Child	**Birth** – Copy of official Birth Certificate or copy of hospital record pending official birth certificate. **Adoption, Guardianship, Foster Care, Court Order**- Copy of official signed and dated legal document	Date of event
Loss of Significant Other	**Divorce, annulment, legal separation, dissolution of domestic partnership** – Copy of *only those pages* of official legal document with file date and judge's signature. **Death** – Copy of death certificate (scan is fine).	Date of event
Gained Citizenship or Residency	Copy of SSN, visa or green card issued within 31 days of event	First day of the pay period following submission of completed forms to HR
Move into or out of Service Area	**Change of residence**- provide copies of travel documents (i.e. bus/plane tickets/itinerary). **Must be 90 days or longer.**	First day of the pay period following submission of completed forms to HR
Loss of Coverage	Official letter of loss of coverage from another employer, insurance carrier or Medicare specifying: • Termination date of coverage • Dependents covered under plan • Plans enrolled (i.e. medical, dental, vision, etc.)	First day of the pay period following submission of completed forms to HR
Gain of Coverage	Official letter of gain of coverage from another employer, insurance carrier or Medicare specifying: • Effective date of coverage • Dependents covered under plan • Plans enrolled (i.e. medical, dental, vision, etc.)	First day of the pay period following submission of completed forms to HR
Unpaid Leave of Absence	Department has completed approved leave of absence process with Workforce Systems	First day of the pay period following submission of completed forms to HR

If your dependent(s) have a different last name, proof of relationship (i.e. marriage/birth certificate) is required upon submission of this form.

If the form or supporting documents contain any personally identifying information, upload them to University of Arizona Box rather than emailing. https://hr.arizona.edu/submit-documents
Label your file Employee Last Name,Employee First Name