How to fill out the Qualifying Status Change Form

THIS IS NOT A FORM – IT IS AN EXAMPLE ON HOW TO FILL OUT THE FORM

Select the correct option for your status change. Make sure to also submit the necessary documentation.

Sign and date the bottom of the form.

Place a check mark beside the type of Qualifying Status Change Event

☐ **Birth/Adoption of new family member**

Date of birth/adoption:_____

Note: Coverage for new dependent(s) is effective the date of birth or date of adoption.

Documentation: Crib Card/Birth Certificate (copy) or legal adoption papers

☐ **Marriage**

Date of marriage:_____

Note: Coverage for new dependent(s) is effective the beginning of the next month from the date received in Benefits.

Documentation: Marriage Certificate (Copy)

☐ **Divorce**

Date of divorce: _____
(date signed by Judge):

Note: A change in enrollment is effective the beginning of the next month from which the divorce occurred.

Documentation: Divorce Decree paperwork (Copy)

☐ **Death of Family Member**

Name of family member:_____

Date of death:_____

Note: Coverage continues through the date of death.

Documentation: Death Certificate (Copy)

☐ **The insurance plan covering your spouse holds an annual open enrollment** at a different time than Saint Paul Public Schools, that results in a significant change in cost or coverage options.

Date of change in coverage options or cost on other plan:_____

Documentation: Copy of Open Enrollment Notice with dates

Change in spouse/ dependent status that changes eligibility for insurance

☐ Spouse or legal dependent(s) gain or loses eligibility for group insurance through his/her employer

Date coverage ended _____
or date began: _____

If loss, is loss of coverage from a group or individual company plan?

☐ Group
☐ Individual (MN Sure, etc)

Documentation: (Required) Document from company showing dependent(s) and date of loss or coverage begin date.

Change in SPPS Employment

☐ You have received a position change that changes the District contribution towards your coverage

☐ PT to FT
☐ FT to PT

Note: Eligibility for change in enrollment varies by circumstance. Coverage is effective the beginning of the next month from the date received in Benefits.

SPPS Married Couple Agreement

☐ You have a qualifying event and your spouse is also an SPPS employee. With the event you are applying for the Married Couple agreement. Both employees must meet eligibility requirements. (Separate application upon request.)

IMPORTANT! Your request for enrollment change must be received in the Benefits Office in Human Resources within thirty **(30) days** of the status change event date for you to be eligible to change your coverage.

Return this form and the enrollment application to:
Human Resources Department, Benefits Office, 360 Colborne, St. Paul, MN 55102
Fax it to 651.221.1495 or
Email to janine.cummins@spps.org

If you have questions call 651.767.8266

Employee Information: Fill out the top as you the employee (MUST BE FILLED OUT COMPLETELY)

Employee Full Name: (Last, First, Middle)	Date of Birth: (Required)	**Type of Change:** ☐ Amended • New Hire – Change (30 days) ☐ Job/Position Change • FTE Change (Hour change) ○ PT to FT ○ FT to PT ☐ Return From Leave ☐ Qualifying Status Change • Birth/Adoption/Death • Marriage/Divorce • Employment Change/Court Order • Different Open Enrollment • Dependent loss or gain of coverage • SPPS Married Couple Agreement	Employee ID:
Street Address:	Last 4 of SSN:		Position Title:
City, State, Zip Code:	☐ Male ☐ Female		
Primary Phone Number:	Alternate Phone Number:		Emergency Contact Name:
Marital Status: ☐ Single ☐ Married	If married is your spouse a SPPS employee? ☐ Yes ☐ No		Relationship:
If yes, provide spouse name and spouse employee ID Full Name:	ID:		Emergency Contact Phone:

-All Medical, Dental and Vision fields must be completed – Failure to complete the form will be considered incomplete and risk being denied.

Medical, Dental and Vision:

Select the medical, dental and vision (vision is an optional coverage) plan
Select the Plan Type – smart care or open access
Select the coverage level – employee only, employee + 1 or family
Waive – the groups below are able to waive their medical coverage.
Please refer to your perspective bargaining agreement for specifics details

Non Cafeteria Plans able to Waive Coverage		Cafeteria Plans able to Waive Coverage	
AFSCME	Bus Drivers	Part time ASAP	Part time Manual Maintenance
Classified Confidential	Custodians	Part time SCSP	Part time SPSO
Educational Asst.	Machinists	Part time Teachers	
Nutrition Services	PEA	Part time cafeteria plan employees that waive medical, must waive all coverage and is not entitled to receive any District Contribution towards benefits.	
Teaching Assistants			

Medical Insurance – HealthPartners **(All Fields Required)**

Select Medical Plan,	*Select Plan Type*	*Select Coverage Level:*
☐ HSA Medical Plan	☐ Smart Care	☐ Single Only
☐ HRA Medical Plan	☐ Open Access	☐ Single Plus One
☐ CoPay Medical Plan		☐ Family

☐ I elect to waive medical coverage (Link: spps.org/benefits)
(Non-Teachers & PT Teachers Only, (PT EE's in a cafeteria plans if Medical is waived all benefits are waived)

Dental Insurance - HealthPartners

Check coverage level desired:

☐ Single Only
☐ Single Plus One
☐ Family
☐ SPPS Married Couple Waive

Vision – EyeMed **Check coverage level desired:**

Note: Your vision exam is covered under your medical plan (if covered). EyeMed is for glasses or contacts.

☐ Single Coverage ☐ Single Plus One
☐ Family Coverage ☐ Waive Coverage

Spending Accounts

If electing for plan year 2020

- Health Savings Account (HSA),
- Flexible Spending Account (FSA) or
- Dependent Flexible Spending (FSAD)

you must complete a separate form, forms are available at spps.org/benefits

Optional Insurance: Put an A for Add, C for Cancel or N for No Change for any of the elections below based on the benefit choices you make. If you do not mark anything, no changes will be made.

Optional Insurance Coverage: Guarantee Issue (GI) is for new hires only, insurance up to the GI amount is guaranteed without underwriting.

If electing spouse or dependent insurance you MUST provide dependent information on the next page.

Amounts must be in increments of $5,000 (excluding Dependent Child)

Add / Cancel / No Change: Enter A C or N		Amount Requested	Add / Cancel / No Change: Enter A C or N		Amount Requested
☐ Employee Optional Life $400,000 Maximum	$150,000 (GI)	$_____	☐ Employee Accidental Death $200,000 Maximum	$100,000 (GI)	$_____
☐ Spouse Optional Life $400,000 Maximum	$25,000 (GI)	$_____	☐ Spouse Accidental Death 50% of Employee AD/D - Maximum $100,000	$50,000 (GI)	$_____
			☐ Dependent Child`	$10,000 (GI)	$10,000 per child

* To elect or increase Employee or Spouse Optional Life up to $400,000, you will be required to fill out the Evidence of Insurability Form (EOI). Please print out the form and follow the instructions on the form and return to the address listed on the form.

** Employee AD/D max $200,000. Spouse AD/D max is 50% of Employee AD/D

Aflac Insurance – Aflac is an optional insurance. Put a check mark in the box for the election you want to make. If you do not mark anything, no changes will be made.

Aflac Group Accident Insurance		Aflac Group Hospital Indemnity Insurance	
Group Accident Low	**Group Accident High**	**Hospital Indemnity Low**	**Hospital Indemnity High**
☐ Employee Only	☐ Employee Only	☐ Employee Only	☐ Employee Only
☐ Employee Plus One	☐ Employee Plus One	☐ Employee Plus One	☐ Employee Plus One
☐ Family	☐ Family	☐ Family	☐ Family

Aflac Critical Illness Insurance **Employee Age**:_____

Non Tobacco Use

☐ Employee Only ☐ Employee Plus One ☐ Family

Tobacco Use

☐ Employee Only ☐ Employee Plus One ☐ Family

Legal Dependent Information:

You must fill out information regarding legal dependents that you are (A) Adding (C) Cancelling or (N) No Change if you are not making any changes.

Circle the appropriate Code (A) Add (C) Cancel or (N) No Change for each election for each legal dependent.

Birth Dates and Social Security numbers are required even if on file.

Make sure to print clearly in each field.

In the example below it shows:

- Mary (Spouse) will be added to Medical and Dental, Spouse AD/D and Aflac Accident.
  There is No Change to Vision and Spouse Life and Mary will be cancelled from Aflac Hospital and Critical.
- James (dependent) will be added to Medical and Dental and there is no change to the other elections.

Legal Dependent Information - Required

Add/Cancel/No Change (Circle One per Dependent)	**Full Name**	**Legal Dependent Relationship**	**Sex M/F**	**Date of Birth** (Required) MM/DD/YYYY	**Social Security #** (Required)
[A] C N Medical [A] C N Dental A C [N] Vision A C [N] Spouse Life [A] C N Spouse AD/D [A] C N Aflac Accident A [C] N Aflac Hospital A [C] N Aflac Critical	First Name: **Mary** Middle Name: **Josephine** Last Name: **Smith**	Spouse	**F**	**01/01/1967**	**123-45-6789**
[A] C N Medical [A] C N Dental A C [N] Vision A C [N] Dependent Life A C [N] Aflac Accident A C [N] Aflac Hospital A C [N] Aflac Critical	First Name: **James** Middle Name: **Martin** Last Name: **Smith**	Dependent Child	**M**	**01/01/2019**	**987-65-4321**
A C N Medical A C N Dental A C N Vision A C N Dependent Life A C N Aflac Accident A C N Aflac Hospital A C N Aflac Critical	First Name: ________ Middle Name: ________ Last Name: ________	Dependent Child			
A C N Medical A C N Dental A C N Vision A C N Dependent Life A C N Aflac Accident A C N Aflac Hospital A C N Aflac Critical	First Name: ________ Middle Name: ________ Last Name: ________	Dependent Child			
A C N Medical A C N Dental A C N Vision A C N Dependent Life A C N Aflac Accident A C N Aflac Hospital A C N Aflac Critical	First Name: ________ Middle Name: ________ Last Name: ________	Dependent Child			

Sign and date the form:

I hereby apply for (or request change in) the coverage(s) as indicated above for which I am eligible under contracts of group insurance issued to my employer. I understand that some coverage(s) require approval of my insurability before they become effective. I authorize payroll deductions for my share of the premiums. I understand that if I am off the payroll with rights to reinstatement and my employment is reinstated within one year, and my optional and dependent coverage(s) is in effect immediately prior to my layoff or leave of absence will be reinstated. My employer will deduct, from my wages, the necessary premiums to effect this reinstatement. This option can be rescinded at any time prior to the date of my reinstatement by sending written notice to my employer.

Signature: _____ Date: _____

Fax: 651.221.1495 **E-Mail: janine.cummins@spps.org**

Mail: Benefits Office, Saint Paul Public Schools, 360 Colborne Street, Saint Paul, MN 55102

Form Submission information:

1. You can submit the form:
   - Scan and email ***completed*** form and documentation to janine.cummins@spps.org or
   - fax it to 651.221.1495 or
   - Mail: Benefits Office, Saint Paul Public Schools, 360 Colborne Street, St Paul MN 55102

What Happens after I Submit Documents and Status Change Form:

- You will receive an email:
  - Once the form has been received at SPPS Benefits
  - If any additional information is needed and
  - You will receive an email once the request has been processed.

- It is the responsibility of each employee to review their benefits summary through Employee Self Service for accuracy of the change.

PLEASE NOTE:
Employees are required every year to make elections during Open Enrollment in October for benefits beginning in January of the following year. Failure to make elections will result in core coverage assignment.