Qualifying Status Change – Basic Information and Process

Outside of Active Enrollment, changes to medical and dental insurance, and flexible spending can only be made within **30 days** before or after a "Qualifying Status Change" (QSC) event, sometimes referred to as a "qualifying life event".

Qualifying Status Changes for medical and/or dental include:
(Documentation requirements shown on page 2)

- **Addition of a dependent** through marriage, birth, adoption, or custody changes.
- **Loss of a dependent** through death, divorce, or becoming ineligible for plan coverage. Note: One dependent's loss of eligibility will not allow you to cancel other eligible dependents (i.e. change from family to single coverage).
- **Spouse/Dependent** gains or loses eligibility for insurance through his/her employer (This does not include coverage loss from an individual policy, this includes such individual policies such as MN Sure)
- **Substantial change in employment** status for you, your spouse's, or your dependent's job that would affect benefit eligibility or benefit coverage (i.e. full to part time or vice versa, termination, change jobs, leave of absence, etc.)
- **Qualified Medical Child Support Order** is issued. A copy of the QMCSO (court document) will be required.
- **Relocation** that affects your benefit elections (i.e. moving outside a medical plan's service area)
- **Annual open enrollment** for your spouse or dependent that occurs at a different time than the SPPS open enrollment and results in a significant change in cost or coverage options.

In addition to the above list, qualifying status changes for dependent care flexible spending reimbursement include:

- **Change in daycare providers**

The Status Change form must be completed and returned with documentation to the Benefits Office within 30 days before or after the event to make the change. Eligibility for change in enrollment varies by circumstance. Coverage typically is effective the beginning of the next month from the date received in Benefits.

Process:

1. **Fill out all pages of the form completely, incomplete forms will not be accepted**
2. Provide documentation necessary to support the change. Status changes without sufficient documentation will not be accepted or processed.
3. Turn in the form with documentation to the SPPS Benefits Office
    a. Benefits Office, 360 Colborne Street, Saint Paul MN 55102
    b. Fax: 651.221.1495
    c. Scan and email to janine.cummins@spps.org
4. When forms with documentation are received in Benefits
    a. You will receive an email receipt through your SPPS email account. If you do not receive receipt within 5 business days please contact the Benefits Office
5. When status change has been reviewed:
    a. When the status change has been approved, or denied an email through your **SPPS** Email account will be sent

If you have questions about a "Qualifying Status Change" contact Benefits at 651-767-8266

Saint Paul Public Schools
A World of Opportunities

Qualifying Status Change

You have requested to make a change in your annual benefits elections. The Saint Paul Schools' group insurance plans are governed by IRS guidelines that permit enrollment changes during the plan year only under specific circumstances called status changes. In order to process your request, we need you to complete this form and return it to our office **within 30 days before or after the event date.**
If your status change requires additional premiums for the previous month, it will be deducted from your paycheck or you will need to pay the amount owed to start coverage.

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 is required and only 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: Janine.cummins@spps.org

If you have questions call 651.767.8266

Qualifying Status Change
2020 Enrollment Form
Saint Paul Public Schools
Plan Year 2020

Employee Full Name: (Last, First, Middle)	Date of Birth: (Required)	**Type of Change:**	Employee ID:
Street Address:	Last 4 of SSN:	☐ 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	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 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 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)

Enter (A / C / or N)		Add / Cancel / No Change:	Amount Requested
☐	Employee Optional Life $400,000 Maximum	$150,000 (GI)	$_____
☐	Spouse Optional Life $400,000 Maximum	$25,000 (GI)	$_____

Enter (A / C / or N)		Add / Cancel / No Change:	Amount Requested
☐	Employee Accidental Death $200,000 Maximum	$100,000 (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 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

Beneficiary: Employee Life and Optional Accidental Death: Employee life insurance coverage provided by Minnesota Life includes an accidental death benefit. The optional accidental death benefit coverage is provided by Assurant Insurance Company. You may designate a beneficiary for either or both of the coverages **on a separate form** which is available at www.spps.org/benefits. In the absence of a beneficiary designation, coverage will provide payment in the following order of priority: 1. Your surviving lawful spouse; 2. Your surviving children in equal shares; 3. Your surviving parents in equal shares; 4. The duly appointed legal representative or your estate

Legal Dependent Information - Required

Add/**C**ancel/**N**o 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 Hospital A C N Aflac Critical A C N Aflac Critical	First Name: ___________ Middle Name:___________ Last Name:___________	Spouse			
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			
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			

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