IRIS REQUIREMENTS FOR A FAMILY STATUS CHANGE

The IRS has generally defined a change in family status to include marriage, divorce or legal separation; birth or adoption of a child; death of a spouse or child; termination or commencement of a spouse’s employment; change in employment from or to full-time or part-time status by the employee or spouse; unpaid leave of absence by the employee or spouse; termination of or substantial reduction in health insurance coverage.

Changes in group health insurance coverage may only be made during the annual open enrollment period, unless there is a Family Status Change as defined by the IRS. A new health insurance enrollment form and appropriate evidence of change must be given to the Employee Benefits Office within 30 days of the event, if an individual wishes to make a change in health care coverage during the calendar year. Late application will not be accepted. The change in coverage and any required contribution will be effective as of the date of the event.

If you wish to change your health insurance coverage election, please enter the date of the event, check one of the boxes, and return with the completed enrollment form and appropriate documentation to substantiate the family status change:

Date of the Event: ________________________________

[ ] Marriage, divorce or legal separation. (Provide marriage certificate or court decree.)

[ ] Birth or adoption of a child. (Provide birth certificate/adoption papers.)

[ ] Death of a spouse or child. (Provide death certificate.)

[ ] Termination or commencement of employment/insurance coverage. (Provide letter from employer confirming date of the event and status of health insurance coverage.)

[ ] Change in employment status from or to full-time or part-time status. (Provide letter from employer confirming date of the event and status of health insurance coverage.)

[ ] Termination of or substantial reduction in coverage provided by the employer. (Provide letter from employer confirming date of the event and status of health insurance coverage.)

[ ] Commencement of an unpaid leave of absence by the employee or spouse. (Provide letter from employer confirming date of the event and status of health insurance coverage.)

[ ] Other loss of eligibility for health insurance coverage, please specify reason: ________________________________ and provide appropriate substantiation.

Signature: ________________________________ Phone: ________________________________

Print: ________________________________ Date: ________________________________