Seattle University
Office of Human Resources
Status Change Request Form

Please fill in the requested information as completely as possible. Return the completed form to the Office of Human Resources. This form must be received no later than 30 days from the date of the status change (You have 60 days to request a status change due to the birth of your child).

Last name (please print)	First name	M.I.	Social Security Number	Department	Ext.

Address	City, State, Zip

DATE OF EVENT: ______________________ EFFECTIVE DATE OF CHANGE: ___________________ (effective 1st of month following event or date of birth for newborn)

Do you or any dependent(s) applying for coverage have coverage with any other health care plan now or within the last three months? This includes coverage through another insurance company, Medicare, a self-insured plan or a group retirement plan.

[NO] If no, please skip the rest of this section and continue.
[YES] If yes, please complete the rest of this section and continue.

Insurance Company Name	Insurance Company Address & Phone #	Employer	Identification/Policy#
Policy Holder Name	Date Coverage Began	Is coverage still in effect? ☐Yes ☐No If yes, will coverage still be in effect when this policy begins? ☐ Yes ☐ No If no, date coverage ended or will end?	Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Medicare
Name of person(s) covered by other insurance:			

<u>Please list those family members for whom you are making changes</u> (You are also able to make election changes to all levels of life and accidental death and dismemberment insurance, please see the Benefits Office for more information.

Relationship	Name	Birth Date	Social Security Number	Add/ Drop	Medical Plan/Vision Plan	Dental	LDA Dependent?
Self				☐Add ☐Drop	☐Preferred ☐Group Health	☐Dental	
☐Spouse ☐LDA				☐Add ☐Drop	☐Preferred ☐Group Health	☐Dental	
☐Daughter ☐Son				☐Add ☐Drop	☐Preferred ☐Group Health	☐Dental	
☐Daughter ☐Son				☐Add ☐Drop	☐Preferred ☐Group Health	☐Dental	
☐Daughter ☐Son				☐Add ☐Drop	☐Preferred ☐Group Health	☐Dental	

**You are also able to make election changes to all levels of life and accidental death and dismemberment insurance, please see the Benefits Office for more information.

Revised 1/3/07

The change in election event(s) on which my request is based is/are:

Check Applicable Box(es) to indicate the Change in Election Event(s) that apply to your situation. Election changes generally cannot be retroactive and must be consistent with the Change in Election Event, as described below. LDA Changes must be accompanied by an LDA Certification or Termination form.

FMLA Leave (Medical Insurance and Health FSA premiums to be paid as follows while on leave): ☐ After-tax, by sending in payments ☐ Pre-tax, by prepayment ☐ Other (as agreed with Benefits Manager)	Change in Marital Status ☐ Marriage ☐ Divorce or annulment ☐ Legal Separation ☐ Death of Spouse	Change in Employment Status that affects Eligibility ☐ Termination or Commencement of Employment ☐ Part-time to full-time or full-time to part-time ☐ Commencement of or return from unpaid LOA
Change in Dependent's Eligibility Under Employer's Plan ☐ Lost eligibility (such as age, student status, marital status) ☐ Gained eligibility (such as age, student status)	Change in Number of Tax Dependents ☐ Birth ☐ Adoption or placement for adoption ☐ Death of dependent	Medicare or Medicaid ☐ Became eligible for Medicare or Medicaid ☐ Lost eligibility for Medicare or Medicaid
Change in Coverage ☐ Significant curtailment of coverage ☐ Addition or significant improvement of Plan Option ☐ Loss of group health coverage under plan of governmental or educational institution ☐ Change in coverage under an employer's plan	Change in Cost ☐ Significant cost increase in coverage ☐ Significant cost decrease in coverage	Special Enrollment Rights under HIPAA ☐ Loss of other group health plan coverage ☐ Acquired new spouse or dependent
Judgments, Decrees and Orders ☐ Order resulting from divorce, legal separation, annulment, or change in custody requiring coverage for dependent	☐ Change in Residence affecting eligibility	☐ Change in LDA eligibility

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with the Plan, and the Administrator has sole discretion to make this determination. If I am requesting an election change to cancel or reduce coverage because (a) I or my family member has become eligible for new or improved coverage (including coverage at a reduced cost) under an employer's plan or under Medicare/Medicaid, or (b) a judgment, decree or order requires an individual other than me to provide accident or health coverage for my child, I certify that such new, improved or court-ordered coverage has already been obtained or is in the process of being obtained for the applicable person.

If my change in election is denied, I understand that I will have to appeal the decision within the time frame specified in the Summary Plan Description for the plan.

If approved, I hereby elect the change(s) noted on the previous page and attest that the change is made on account of and is consistent with the change in election event.

____________________________ __________ ____________________________ ______________

Signature Date Administrator's Signature Date