Quincy Public Schools

Benefits Change Form

For BOE Use Only
Event / Date _____
Input Elections _____

Quincy Public Schools Employee Information

Name (Last, First, Middle Initial)	Social Security #	Building Location	
Address	City, State, Zip	Gender (M/F)	Phone

Date of Event: _____ **NOTE:** This form must be received by the Benefits Coordinator **within 30 days** of the event.

Enroll/Add/Change
- ☐ Birth/Adoption
- ☐ Marriage
- ☐ Other Qualified Adult
- ☐ Change to Full Time
- ☐ Other: _____ _____

Enroll/Add
- ☐ Legal Guardianship
- ☐ Divorce
- ☐ Involuntarily Lost Coverage
- ☐ Other: _____ _____ _____

Delete Dependent
- ☐ Death of Dependent
- ☐ Divorce
- ☐ Dependent newly eligible for own benefits due to job commencement, job change, or their employer's Open Enrollment.

Cancel
- ☐ Cancel coverage for me and my dependents:

Reason: _____ _____ _____

Check the appropriate box(es) to indicate where you wish to make an addition or deletion to your current benefits coverage.

Health Plan
- ☐ PPO 2500
- ☐ HDHP 4000
- ☐ HRP
- ☐ Waive

Dental Plan
- ☐ High Plan
- ☐ Low Plan
- ☐ Waive

Vision Plan
- ☐ Enroll
- ☐ Waive

Voluntary Life
- ☐ Employee – Request Change to $_____
- ☐ Spouse – Request Change to $_____
- ☐ Child – Request Change to ☐ $5,000 or ☐ $10,000
- ☐ Waive

*Canceling or waiving medical coverage also cancels prescription drug coverage. If you are canceling or waiving medical coverage because you are covered under another individual's medical plan, please provide the following information:

Name of Policy Holder: _____ Group Number: _____

Name of Employer: _____

Employee and Dependent Information – You must complete the following section for all additional and/or deletions. Enter the information for each individual, and then write **A** in the appropriate benefit column to add your coverage or **D** to delete from your coverage, or **C** to change.

Name (Last, First, Middle Initial)	Social Security Number	Relation-ship Code	Gender (M/F)	Date of Birth	Medical	Dental	Vision	Life

Social Security Number not required for newborns.
Relationship Codes: EE = QPS Employee, SP = Spouse, C = Child, OQA = Other Qualified Adult

Medicaid or Medicare – Are any of the dependents listed above eligible for Medicaid or Medicare? If yes, provide the following information and attach a copy of the Medicaid or Medicare card.

First Name	Medicaid or Medicare #	Part A (Hospital) Eff. Date	Part B (Medical) Eff. Date	Part D (RX) Eff. Date

Authorization and Signature – The information provided above is correct to the best of my knowledge. I have reviewed the benefit enrollment materials and agree to the terms and conditions listed there. I authorize deductions, if appropriate, for my benefit choices based on the current rate and any future rate changes (increases or decreases).

_____ _____

Signature of QPS Employee Date Signed