

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 <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Other Qualified Adult <input type="checkbox"/> Change to Full Time <input type="checkbox"/> Other: _____ _____ _____	Enroll/Add <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Divorce <input type="checkbox"/> Involuntarily Lost Coverage <input type="checkbox"/> Other: _____ _____ _____	Delete Dependent <input type="checkbox"/> Death of Dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent newly eligible for own benefits due to job commencement, job change, or their employer's Open Enrollment.	Cancel <input type="checkbox"/> Cancel coverage for me and my dependents: Reason: _____ _____ _____
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Check the appropriate box(es) to indicate where you wish to make an addition or deletion to your current benefits coverage.

Health Plan <input type="checkbox"/> PPO 2500 <input type="checkbox"/> HDHP 4000 <input type="checkbox"/> HRP <input type="checkbox"/> Waive	Dental Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Low Plan <input type="checkbox"/> Waive	Vision Plan <input type="checkbox"/> Enroll <input type="checkbox"/> Waive	Voluntary Life <input type="checkbox"/> Employee – Request Change to \$ _____ <input type="checkbox"/> Spouse – Request Change to \$ _____ <input type="checkbox"/> Child – Request Change to <input type="checkbox"/> \$5,000 or <input type="checkbox"/> \$10,000 <input type="checkbox"/> Waive
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*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
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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
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