St. Johns County School District

ST. JOHNS COUNTY SCHOOL DISTRICT

CHANGE IN FAMILY STATUS ELECTION FORM
MEDICAL-DENTAL-VISION

Employee Name:_____

Employee Address: _____

Employee ID #: _____ Effective Date:_____

I understand that the change in my benefit election must be necessitated by and consistent with the change in family status and that change must be acceptable under the Health Insurance Portability Act (HIPAA). All enrollment forms, required documents listed below, and Business Plus), Employee On-Line insurance changes must be completed and returned within 30 days of the occurrence and supporting documentation submitted at the time of filing. Please attach the completed enrollment forms.

If you are <u>enrolling dependents</u> into your insurance you must provide the following documents:

<u>Spouse:</u> Certified Copy of Marriage Certificate **<u>AND</u>**
One of the following documents:

1) A copy of the front page of your 2021 Federal Tax Return confirming this dependent is your spouse.
2) A document such as a recurring monthly household bill or statement of account. **This document must have the following information**: listing you and your spouse's name, the current date within the past 60 days, and your current mailing address.

<u>Children:</u> Certified Copy of Birth Certificate or Adoption Certificate naming you or your spouse as the child's parent. If you are covering a stepchild and your spouse is not a covered dependent, you must also provide documentation of your current relationship with your spouse as requested above.

— I certify that I have incurred the following change in my family status:

— Marriage (Marriage Certificate with Seal)

— Divorce (Final Divorce Degree: First and last page only)

— Birth, adoption, or placement for adoption of a child (Birth Certificate with parents' names)
(Court Adoption paperwork)

— Death of my spouse and/or dependent (Certified Death Certificate)

— Termination or commencement of employment by my spouse (Employer statement with effective insurance date or Employer insurance termination date)

— Switching from part-time to full-time (or vice-versa) employment on part of my spouse or myself
(Employer document stating part-time to full-time or vice-versa)

— My dependent satisfies or ceases to satisfy eligibility requirements for coverage
(Example: Medicaid or Florida Health Kids with qualifying date)

— Other (briefly explain the change in family status in space provided below):

_____

_____

Employee Signature: _____ Date:_____

Please return this signed election form to the St. Johns County School District Human Resource Benefits Department Attention: Michelle Price (904) 547-7549 by October 31, 2022.