QUALIFIED STATUS CHANGE FORM

(Please Print)

Complete and attach the appropriate enrollment form for the requested change.

☐ **Health** ☐ **Life** ☐ **Dental** ☐ **Other Supplemental** _____

PART 1: ELIGIBLE PLAN PARTICIPANT INFORMATION

SSN: | | | | | | | | | | **EEID:** 0 0 | | | | | | | |

Name: _____

Complete Mailing Address: _____

Work Phone: ( ) _____ **Home Phone:** ( ) _____ **Paid:** ☐ Bi-weekly ☐ Monthly

Department / Agency: _____

PART 2: TYPE OF QUALIFYING STATUS CHANGE

Please indicate your Qualifying Status Change Event below and return this form to the PEOPLE FIRST SERVICE CENTER along with the required documentation. **REFER** to the back of this form for a list of the QSC codes and required documentation.

I have incurred or will incur a Qualifying Status Change (QSC) event on: ☐☐/☐☐/☐☐☐☐
month day year

and therefore request the following (please check (✓) your choice):

☐ Change from Individual to Family Coverage

☐ Change from Family to Individual Coverage

☐ Re-enroll for Coverage

☐ Terminate Coverage

My Qualifying Status Change Event is:
(refer to back to complete this section)

QSC Code: _____

QSC Name: _____

I have attached the following required documentation: _____

Employee Signature: _____ **Date:** _____

PART 3: IMPORTANT INFORMATION

- This form, documentation of the Qualifying Status Change Event, and the appropriate insurance forms must be submitted to the People First Service Center within thirty-one (31) days after the date of the event.
- If documentation is not readily available, complete and submit this form and the appropriate insurance forms within the thirty-one (31) day period. Obtain the required documentation and forward to the People First Service Center within 60 days of the coverage change effective date.
- If this form and the appropriate insurance forms are received more than thirty-one (31) days after the event, the request for change(s) will be denied.
- **Mail** the required forms and documentation to:

State of Florida
People First Service Center
Post Office Box 6830
Tallahassee, FL 32314

or **Fax** to: (904) 828-6092

QUALIFYING STATUS CHANGE CODES, EVENTS AND DOCUMENTATION REQUIREMENTS

Code	Qualifying Event	Documentation Requirements
1	Marriage	**Marriage Certificate, Proof of Eligibility if adding other Dependents**
2	Divorce	**Divorce Decree**
3	Commence Unpaid Leave by Participant (including Military Leave)	Documentation will be provided by your Employer
4	Return from Unpaid Leave by Participant (including Military Leave)	**Proof of Eligibility if adding Dependents**
5	Death of Spouse or Dependent	**Death Certificate**
6	Ineligibility of Dependent	N/A
7	Birth or Adoption (including foster care placement, guardianship, adoption placement)	**Birth Certificate, Adoption Papers, Court Documents, Proof of Eligibility if adding other Dependents**
8	Commencement of Employment by Participant's Spouse (resulting in coverage)	Documentation will be provided by your Employer
9	Termination of Spouse's Employment (resulting in termination of coverage)	Documentation will be provided by your Employer
10	Commence Unpaid Leave by Spouse (resulting in loss of coverage)	Documentation will be provided by your Employer
11	Return from Unpaid Leave by Spouse (resulting in an election of coverage)	Documentation will be provided by your Employer
12	Change from Part-Time to Full-Time by Participant	Documentation will be provided by your Employer
13	Change from Full-Time to Part-Time by Participant	Documentation will be provided by your Employer
14	Change from Part-Time to Full-Time by Spouse (resulting in gain of coverage)	Documentation will be provided by your Employer
15	Change from Full-Time to Part-Time by Spouse (resulting in loss of coverage)	Documentation will be provided by your Employer
16	Special Enrollment for Loss of other Coverage	Documentation will be provided by your Employer
17	Change in Coverage due to Spouse's Employment (open enrollment, health plan addition or deletion; by a non-state employer)	N/A
18	Change from Career Service to SES or SMS (results in eligibility for a premium-free coverage)	Documentation will be provided by your Employer
19	Change from SES or SMS to Career Service (results in loss of eligibly for premium-free coverage)	Documentation will be provided by your Employer
20	Change into Spouse Program	**Spouse Program Enrollment Form**
21	Change out of Spouse Program	**Spouse Program Enrollment Form**
22	Termination of Participant's Employment (except retirement)	Documentation will be provided by your Employer
23	Dependent satisfies Eligibility Requirements	**Proof of Eligibility if adding Dependents**
24	Retirement	Documentation will be provided by your Employer
25	Reversion due to No Documentation within 60 days	N/A
26	Cancel for Non-Payment	N/A
27	Commencement or Return from Family Medical Leave (FMLA)	Documentation will be provided by your Employer
28	Change of Residence resulting in Loss of Eligibility (moved outside HMO service area)	**Proof of Address Change**
29	Change from Retirement to Active Employment by Participant	Documentation will be provided by your Employer
30	Court Order that requires Coverage for a Child under the Employee's Plan	**Copy of Court Order**
31	Court Order that requires Spouse, Former Spouse or Other Individual to provide Coverage for a Child	**Copy of Court Order and Proof of other Coverage**
32	Layoff of Participant	Documentation will be provided by your Employer
33	Return of Participant from Layoff	**Proof of Eligibility if adding Dependents**
34	Layoff of Participant's Spouse	**Proof of Eligibility if adding Dependents**
35	Return of Participant's Spouse from Layoff	N/A
36	Gain of Entitlement for Medicare or Medicaid (other than coverage solely for pediatric vaccines)	**Letter or other Documentation of Gain of Eligibility**
37	Loss of Entitlement for Medicare or Medicaid (other than coverage solely for pediatric vaccines or to other Group Health Plan Sponsored by a Governmental or Educational Entity, including Healthy Kids Programs)	**Letter or other Documentation of Eligibility. Proof of Eligibility if adding Dependents. Certificate of Coverage if Pre-Existing Condition applies.**
38	Termination and Rehire in Same Calendar Year with Less than One Full Calendar Month Break in Service	N/A
39	Termination and Rehire in Same Calendar Year with More than One Full Calendar Month Break in Service	**Proof of Eligibility if adding Dependents**
40	Death of Participant	**Death Certificate**
44	Significant Cost Increases or Decreases	**Letter from Dependent Care Provider**

NOTE: those **bolded** requirements are the responsibility of the covered participant.

21-May-04