Benefits & You!

MIAMI-DADE COUNTY CHANGE IN STATUS FORM
Change In Status/Election Form

MIAMI–DADE

NAME: LAST	FIRST	MI	SOCIAL SECURITY #

ADDRESS (STREET / PO BOX)			

CITY	STATE	ZIP	DAYTIME PHONE
			( )

PLEASE INDICATE THE TYPE OF MID PLAN YEAR EVENT INCURRED:

Some Permitted Mid Plan Year Changes*		Documentation Required
_____	Loss of coverage eligibility for (dependent) child or spouse	Letter of explanation from Employer or insurance company with cancellation date of coverage
_____	Armed Forces (dependent) child or spouse	Copy of enlistment papers
_____	Marriage	Marriage license
_____	Divorce	Divorce decree
_____	Death (dependent) child or spouse	Death certificate
_____	Birth of a child* (60 days for newborns)	Birth certificate (when it becomes available)
_____	Adoption of or placement for adoption of child*	Finalized Adoption agreement or letter from placement agency
_____	Change from FT to PT employment or vice versa ● SELF ● SPOUSE ● DEPENDENT	Letter of explanation from employer w/ loss of coverage eligibility or the effective date of insurance.
_____	Unpaid leave of absence ● SELF ● SPOUSE ● DEPENDENT ● Start ● Return (only if dependents coverage was dropped when leave started)	Letter of explanation from employer with effective date of unpaid leave.
_____	Ineligibility of dependent child ● AGE ● MARRIAGE	Birth certificate, marriage license, or letter from registrar(with insurance effective date)
_____	Beginning or end of employment of spouse/dependent	Letter from employer w/ loss of coverage eligibility and termination date or effective date of insurance and date of full time employment
_____	Expiration of COBRA (spouse or child)	Letter from employer, plan description or insurance provider
_____	Significant change in health coverage due to spouse's or dependent employment* (please explain): _____ _____	
_____	Court Order*	Court Order
_____	Medicare* ● SELF ● SPOUSE ● DEPENDENT	Copy of Medicare card showing effective date or another form of documentation showing effective date of coverage
_____	Medicaid* ● SELF ● SPOUSE ● DEPENDENT	Copy of Medicaid card or relevant letter indicating effective date
_____	Open Enrollment* ● SPOUSE ● DEPENDENT	Copy of enrollment form or letter from employer with effective date of coverage
_____	Change in Residence* ● SELF ● SPOUSE ● DEPENDENT	Utility Bill, change in address form, lease, mortgage agreement

PLEASE INDICATE THE CHANGES YOU WISH TO MAKE DUE TO THE MID PLAN YEAR EVENT INDICATED ABOVE. PERMITTED ELECTION CHANGES MUST BE CONSISTENT WITH THE EVENT.*

Dependent Care Spending Account (Pre-Tax)
- _____ Terminate account
- _____ Start account (election form must be completed)
- _____ Change existing account (election form must be completed)

Healthcare Spending Account* (Pre-Tax)
- _____ Terminate account
- _____ Start account (election form must be completed)
- _____ Change existing account (election form must be completed)

Short Term Disability Income (Post-Tax)
- _____ Terminate coverage
- _____ Start coverage (evidence of insurability and election forms must be completed)

Legal (Post-Tax)
- _____ Terminate coverage
- _____ Change to single coverage
- _____ Change to Employee + 1
- _____ Change to family coverage

Long Term Disability Income (Post-Tax)
- _____ Terminate coverage
- _____ Start coverage (evidence of insurability and election forms must be completed)

Group Medical Insurance (Pre-Tax)
(Please submit health insurance status change form)
- _____ Terminate
- _____ Change to single coverage
- _____ Change to Employee + Child(ren)
- _____ Change to Employee + Spouse
- _____ Change to family coverage
- _____ No change in premium, but addition or deletion of dependent.

Group Dental Insurance (Pre-Tax)
(Please submit health insurance status change form)
- _____ Terminate coverage
- _____ Change to single coverage
- _____ Change to Employee + 1
- _____ Change to Employee + 2 or more
- _____ No change in premium, but addition or deletion of dependent

GROUP VISION INSURANCE (Pre-Tax)
(Please submit health insurance status change form)
- _____ Terminate coverage
- _____ Change to single coverage
- _____ Change to Employee + 1
- _____ Change to Employee + 2 or more
- _____ No change in premium, but addition or deletion of dependent

This is to certify that on _____ , 20____ I incurred the events indicated above and therefore wish to modify my benefits and salary reduction amounts as indicated. **I understand that the change(s) requested must be consistent with the event and that I must provide documentation of all events.** If documentation is not readily available, submit this form within 45 days (60 days for newborns) of the event. Forward documentation supporting your election change request when available. Review of request will be pending receipt of documentation.

Signature _____ Date _____

Completed form must be received within 45 days of the event (60 days for newborns). Submit documentation when available:

FAX 305-375-1368

Please keep pink copy for your records.

*SEE BACK FOR FURTHER DETAILS

OFFICE USE ONLY

Approved _____ Complete_____

Effective date _____

Pending documentation _____

_____

Denied _____

_____

Notes _____

Mid-year plan election changes must be consistent with the event. Within 45 days of an event (60 days for newborns, adoptions, or placement for adoption) which is consistent with one of the event categories that follow, you must complete and submit a Change in Status (CIS) Election Form. You may download this form from the Benefits website at www.miamidade.gov/benefits. Documentation supporting your election change request is required. Contact your DPR or the Benefits Administration Section to obtain this form, if you do not have access to a computer. Upon the approval and completion of processing your election change request, the deductions for your existing benefit election(s) will be stopped or modified (as appropriate) the first day of the pay period or the first day of the month after an approved mid-year plan election change request has been received. Changes to add a new dependent become effective the first day of the month following receipt of a timely request with the exception of birth, adoption, or placement for adoption which become effective as of birth or the earlier of: a) adoption or b) placement for adoption. Payroll changes to add a newborn are processed in accordance with Florida statute 641.31(9). If the CIS form is received by the Benefits Administration Section within the first thirty-one (31) days from birth, adoption, or placement for adoption, the premium is waived for the first 31 days. If the CIS form is received after the first 31 days, but within sixty (60) days of the event, the new premium will be charged retroactive to the birth or earlier of: a) adoption or b) placement for adoption. Payroll changes to delete a dependent, other than those events specified in this paragraph, become effective the first day of the pay period following receipt by the Benefits Administration Section. If a request to delete an ineligible dependent is received after the 45 day deadline, the dependent's coverage will be cancelled, but the dependent premium will continue through the end of the plan year. Generally, mid-year plan pre-tax election changes can only be made prospectively and no earlier than the first payroll after your election change request has been received, unless otherwise provided by law. If your election change is denied, you will have 30 days from the date of your denial to file an appeal. For more information, refer to the "Appeals Process for Denied Change in Status Requests" in your Benefits Handbook.

Change In Status (CIS) Events. Refer to the section "Changing Your Coverage" in the online Benefits Handbook for more information and clarification.

Circumstances constituting valid CIS Events. Refer to the section "Changing Your Coverage" in the online Benefits Handbook for more information and clarification.

Notes:

1. **"Gain or loss of dependents eligibility status"** – An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include a change in age or employment status.

2. **"Change in Residence**" – will only be considered a Qualifying Event if the dependent moves to an area that is out the AvMed or PHCS networks.

3. **"Dependents Eligibility Status"** – under the Patient Protection and Affordability Care Act (PPACA), student status and marital status is no longer considered a Qualifying Event for dependents up to age 26+.

Special Consistency Rules. Refer to the section "Changing Your Coverage" in the online Benefits Handbook for more information and clarification.

Changes in Cost or Coverage Events. Refer to the section "Changing Your Coverage" in the online Benefits Handbook for more information and clarification.

HIPAA's Special Enrollment Provisions. Except for your employer's health FSA plan, your employer's group health plans are subject to HIPAA's special enrollment rights which provide that an IRC125 cafeteria plan may permit an employee to change a salary reduction election due to birth, adoption, or placement for adoption. Pre-tax coverage is on a prospective basis only like any other permitted mid-year plan election change.

CHIPRA amends the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act to require employer-sponsored group health plans to permit employees or their dependents to enroll in the plan if they lose eligibility for Medicaid or CHIP, or if they become eligible for premium assistance under Medicaid or CHIP. An individual who requests enrollment within 60 days of losing or becoming eligible for Medicaid or CHIP must be enrolled even if there is no open enrollment period, and without any penalties for late enrollment.

Certain Judgment, Decree or Court Order. Refer to the section "Changing Your Coverage" in the online Benefits Handbook for more information and clarification.