HUMAN RESOURCES DEPARTMENT – BENEFITS SECTION
CITY OF FORT LAUDERDALE CHANGE IN STATUS FORM

Rev: 2 | **Date:** 12/13/2023 | **Print Date:** 12/13/20233

Employee Last Name (Print)	First Name (Print) MI	Employee ID Number
Email	Work Phone	Cell 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/Domestic Partner (DP)	Marriage Certificate or Domestic Partner Affidavit
___ Divorce/Termination of Domestic Partnership (DP)	Divorce decree or Letter from employee stating they are terminating their Domestic Partnership with the name of their DP and the termination effective date included
___ Death (dependent) child or spouse/DP	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's 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*/CHIP ☐ SELF ☐ SPOUSE ☐ DEPENDENT	Copy of Medicaid/CHIP card or relevant letter indicating effective date
___ Open Enrollment* ☐ SELF ☐ 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.*

Group Medical Insurance (Pre-Tax)
___ Terminate coverage
___ Change to Single coverage
___ Change to Employee + Spouse/DP
___ Change to Employee + Child
___ Change to Employee + Children
___ Change to Family coverage
___ No change in premium. Add/Delete Dependent

Group Dental Insurance (Pre-Tax)
___ Terminate coverage
___ Change to Single coverage
___ Change to Employee + Spouse/DP
___ Change to Employee + Child(ren)
___ Change to Family coverage
___ No change in premium. Add/Delete Dependent

Group Vision Insurance (Pre-Tax)
___ Terminate coverage
___ Change to Single coverage
___ Change to Employee + Spouse/DP
___ Change to Employee + Child(ren)
___ Change to Family coverage
___ No change in premium. Add/Delete Dependent

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

Dependent Care Spending Acct. (Pre-Tax)
___ Terminate account
___ Start account
___ Change existing account (election form must be completed)

Group Term Life Insurance
___ Terminate account
___ Start account
___ Change existing account (election form must be completed)

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 30 days (60 days for newborns, newborns adopted/placed for adoption) of the event and forward documentation supporting your election change request as soon as available. **REVIEW OF ALL REQUESTS WILL BE PENDING RECEIPT OF DOCUMENTATION.**

Signature _____ Date _____

The Benefits Section must receive this completed form within 30 days from the date of the event (60 days for newborns, newborns adopted/placed for adoption or Certain Special Enrollment Rights). Change requests received after the applicable 30 or 60 day time limit will not be processed.

Submit documentation as soon as available to: healthyliving@fortlauderdale.gov or FAX: 954-828-5328

*** SEE BACK FOR FURTHER DETAILS**

Approved by: Jerome Post, Director of Human Resources
Uncontrolled in hard copy unless otherwise marked

WE BUILD COMMUNITY

Mid-year plan election changes must be consistent with the event. Within 30 days from the date of an event (60 days for newborns, newborns adopted/placed 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.fortlauderdale.gov/benefits. Documentation supporting your election change request is required. Contact the Benefits 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). Changes to add a new dependent become effective the first of the following month providing receipt of a timely request with the exception of birth, newborn adoption, or placement for newborn adoption which become effective as of birth or the earlier of: a) newborn adoption or b) placement for newborn adoption. Payroll changes to add a newborn are processed in accordance with Florida statute 641.31(9). If the CIS form is received by Employee Benefits Administration Section within the first thirty-one (31) days from birth, newborn adoption, or placement for newborn 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) newborn adoption or b) placement for newborn adoption. Generally, mid-year plan pre-tax election changes can only be made prospectively.

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 plan Network.

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+ for the medical plans.

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

Child Health Insurance Program Reauthorization Act (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.

Return Form To: The Benefits Section/Human Resources Department
Address: 290 NE 3 Ave., Fort Lauderdale, FL 33301
Phone: 954-828-5160; Fax: 954-828-5328; email: healthyliving@fortlauderdale.gov

Please keep a copy for your records.