Grafton School District

Preparing Learners for a Dynamic Tomorrow
Every Student ~ Every Day

Family Status and Benefit Change Form

Changes during the year
Please know that you can change your coverage between annual enrollments only if you have a change in status, as defined by federal law. A change in status happens when: you marry, divorce or legally separate; a child joins your family through birth or adoption; your spouse becomes employed, loses his or her job or involuntarily loses medical coverage; your spouse or dependent child dies; your dependents become ineligible for coverage; you or your spouse have a change in job status from full-time to part-time or vice versa; you or your spouse take an unpaid leave of absence; you or your spouse have a significant change in health coverage due to a change in your spouse's employment. If you have a change in status, you have only 30 days to change your coverage. Furthermore, the requested change must be consistent with the event.

Please complete this benefits change form if you have experienced a change in family status (marriage, birth of a child, adoption, divorce, death of a spouse/partner or child, etc.); the benefits that you chose at the beginning of the plan year may be affected. Return the signed form to HR-Benefits **within 30 days** of the event.

Name: _____
Social Security Number: _____

Family Status Change:
Indicate the family status change by marking an "X" in the appropriate box.

☐ Marriage ☐ Divorce ☐ Death of Spouse ☐ Birth or Adoption of Child

☐ Change in spouse's / employment ☐ Change in dependent eligibility ☐ Other: _____

Date of event: _____

Effective date of change: _____

Authorization:

I understand that I may be required to provide the appropriate documentation for any of the changes in family status that I have checked above. The family status and participation changes will be reviewed.

I hereby elect the participation change(s) noted on the accompanied enrollment forms* and contest that the change is caused by and consistent with the change in family status.

Employee Signature _____ Date _____

* Complete health insurance enrollment form and/or dental enrollment form indicating level of coverage and covered dependent information.