



Miami-Dade County BENEFIT ELECTION CHANGE FORM

Attach a Flex Change In Status Form if changing a pre-tax benefit election due to a valid qualifying event.

For Office Use Only
 Flex Approval: YES NO
 Effective Date: _____
 Group #: _____

Return form to: Benefits Administration\Human Resources Dept., SPCC - 111 NW 1st Street, Suite 2340, Miami, FL 33128
 Phone (305) 375-4288 Fax (305) 375-2964

Employee Last Name (Print)	First Name (Print)	MI	Social Security#
Department	Phone Number		Cell Phone

Change requests are processed prospectively and premium changes, if any, take effect the beginning of the next pay period following receipt of your request. For exceptions and related information, refer to the Benefits Handbook at <https://www8.miamidade.gov/global/humanresources/benefits/home.page>.

1. **ADD DEPENDENT(S)** (Check one box only) **CANCEL DEPENDENT(S)**

Qualifying Event (QE) Type _____ QE DATE _____

Comments _____

LAST NAME	FIRST NAME	SOCIAL SEC #	Date of Birth MMDDYYYY	Gender	Relationship	Provider ID#	Medical	Dental	Vision
<i>Spouse\DP</i>				<input type="checkbox"/> Male <input type="checkbox"/> Female					
<i>Child</i>				<input type="checkbox"/> Male <input type="checkbox"/> Female					
<i>Child</i>				<input type="checkbox"/> Male <input type="checkbox"/> Female					
<i>Child</i>				<input type="checkbox"/> Male <input type="checkbox"/> Female					
<i>Child</i>				<input type="checkbox"/> Male <input type="checkbox"/> Female					

2. **CANCEL PLAN ELECTIONS** - Complete this section only if you wish to **OPT-OUT OF PARTICIPATION IN A BENEFIT PLAN**.

<input type="checkbox"/> MEDICAL PLAN	<input type="checkbox"/> DENTAL PLAN	<input type="checkbox"/> VISION PLAN	<input type="checkbox"/> OPTIONAL LIFE
<input type="checkbox"/> GROUP LEGAL	<input type="checkbox"/> SHORT-TERM DISABILITY	<input type="checkbox"/> LONG-TERM DISABILITY	

After open enrollment, you may cancel any post-tax benefit plan (Group Legal, Short-Term, or Long-Term Disability Plans) without a penalty. **If you cancel a pre-tax benefit plan subject to the IRC Section 125 salary reduction provisions, such as medical, dental and vision, you will still be required to pay the employee premium (if any) for the remainder of the year.** Once you cancel any benefit plan (pre-tax or post-tax), you will not have another opportunity to re-enroll until the next open enrollment, unless you experience a family status change or HIPAA qualifying event. Your signature below acknowledges that you understand and agree to these conditions.

3. **NAME CHANGE**

From	To	Effective	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Signature _____ Date _____

USE THIS FORM TO REPORT THE CHANGES LISTED BELOW TO THE INSURANCE CARRIER

For more information, refer to the online Benefits Handbook at

<https://www8.miamidade.gov/global/humanresources/benefits/home.page>.

1. **Change in Enrollment Level** - Adding or cancelling dependents with a valid family status qualifying event (QE). You must also attach the Flex Change in Status (CIS) form and submit both to Benefits Administration\Human Resources Department within 45 days (60 days for birth/adoption).
2. **Election to Opt-Out** – If you opt-out or cancel your participation in a benefit plan, you cannot re-apply until the next open enrollment, unless you experience a family status or HIPAA qualifying event. If you cancel a pre-tax benefit plan subject to the IRC Section 125 salary reduction provisions, such as medical, dental and vision, you will still be required to pay the employee premium (if any) for the remainder of the year. **Non-bargaining employees:** Opting-out of (cancelling) County-provided medical coverage will not eliminate your 5% base salary contribution towards the County's cost of healthcare.

General Information

Valid qualifying events (QE) include, but not limited to:

- **Change in your marital status** (marriage or divorce)
- **Change in number of dependents** (birth, adoption/placement for adoption, gain/loss of dependent eligibility, death of dependent)
- **Gain or loss of other group health coverage** (Medicare/Medicaid/FL Kid Care, expiration of COBRA)
- **Court order**
- **Change in employment status** (beginning/end of employment of a spouse resulting in gain or loss of insurance coverage)
- **Unpaid leave of absence**
- **Change from part-time to full-time employment status or vice versa**

Include evidence supporting the QE, but do not delay submission of your Change in Status (CIS) and Benefit Election Change forms while you gather the documentation. Submit the forms to your DPR and forward your documentation as soon as it becomes available. Your existing elections will be stopped or modified (as appropriate) upon approval of your change request. Generally, mid-year pre-tax election changes are made prospectively. That is, no earlier than the beginning of the pay period following receipt by Benefits Administration\Human Resources Dept. New dependents 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.

Loss of Eligibility for Dependent Children – Under Age 26

The Patient Protection and Affordable Care Act (PPACA) extended the limiting age for dependent children to the end of the calendar year the dependent turns age 26. Marital status, financial dependency, or student status are no longer applicable. Consequently, you cannot remove a dependent child from coverage due to marriage, or initial employment, unless the child gains other group insurance and enrolls in it. Moving out of the employee's home and losing financial dependency on the parent are not QEs that would permit the dependent's coverage to be canceled.

Loss of Eligibility – Adult Children Age 26+ to 30

- Marriage/Domestic Partnership
- Acquiring dependent children
- Becoming eligible for group medical coverage
- Relocating outside of Florida (unless FT/PT student)
- Entering Military Service

Premium Changes

Benefits Administration\Human Resources Dept. will process the change in premium the beginning of the pay period following receipt of your CIS request. The full premium is charged for the affected pay period, regardless of the number of days you (or dependent) had coverage. The payroll deduction will not be prorated based on the number of days coverage was active in the affected pay period. Refer to the online Benefits Handbook for additional information.

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 payroll deduction will continue through the end of the plan year.

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
<input type="checkbox"/> Loss of coverage eligibility for (dependent) child or spouse	Letter of explanation from Employer or insurance company with cancellation date of coverage
<input type="checkbox"/> Armed Forces (dependent) child or spouse	Copy of enlistment papers
<input type="checkbox"/> Marriage	Marriage license
<input type="checkbox"/> Divorce	Divorce decree
<input type="checkbox"/> Death (dependent) child or spouse	Death certificate
<input type="checkbox"/> Birth of a child* (60 days for newborns)	Birth certificate (when it becomes available)
<input type="checkbox"/> Adoption of or placement for adoption of child*	Finalized Adoption agreement or letter from placement agency
<input type="checkbox"/> 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.
<input type="checkbox"/> 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.
<input type="checkbox"/> Ineligibility of dependent child ● AGE ● MARRIAGE	Birth certificate, marriage license, or letter from registrar(with insurance effective date)
<input type="checkbox"/> 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
<input type="checkbox"/> Expiration of COBRA (spouse or child)	Letter from employer, plan description or insurance provider
<input type="checkbox"/> Significant change in health coverage due to spouse's or dependent employment* (please explain): _____	
<input type="checkbox"/> Court Order*	Court Order
<input type="checkbox"/> Medicare* ● SELF ● SPOUSE ● DEPENDENT	Copy of Medicare card showing effective date or another form of documentation showing effective date of coverage
<input type="checkbox"/> Medicaid* ● SELF ● SPOUSE ● DEPENDENT	Copy of Medicaid card or relevant letter indicating effective date
<input type="checkbox"/> Open Enrollment* ● SPOUSE ● DEPENDENT	Copy of enrollment form or letter from employer with effective date of coverage
<input type="checkbox"/> 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.*

<p>Dependent Care Spending Account (Pre-Tax)</p> <input type="checkbox"/> Terminate account <input type="checkbox"/> Start account (election form must be completed) <input type="checkbox"/> Change existing account (election form must be completed)	<p>Legal (Post-Tax)</p> <input type="checkbox"/> Terminate coverage <input type="checkbox"/> Change to single coverage <input type="checkbox"/> Change to Employee + 1 <input type="checkbox"/> Change to family coverage	<p>Group Dental Insurance (Pre-Tax) (Please submit health insurance status change form)</p> <input type="checkbox"/> Terminate coverage <input type="checkbox"/> Change to single coverage <input type="checkbox"/> Change to Employee + 1 <input type="checkbox"/> Change to Employee + 2 or more <input type="checkbox"/> No change in premium, but addition or deletion of dependent
<p>Healthcare Spending Account* (Pre-Tax)</p> <input type="checkbox"/> Terminate account <input type="checkbox"/> Start account (election form must be completed) <input type="checkbox"/> Change existing account (election form must be completed)	<p>Long Term Disability Income (Post-Tax)</p> <input type="checkbox"/> Terminate coverage <input type="checkbox"/> Start coverage (evidence of insurability and election forms must be completed)	<p>GROUP VISION INSURANCE (Pre-Tax) (Please submit health insurance status change form)</p> <input type="checkbox"/> Terminate coverage <input type="checkbox"/> Change to single coverage <input type="checkbox"/> Change to Employee + 1 <input type="checkbox"/> Change to Employee + 2 or more <input type="checkbox"/> No change in premium, but addition or deletion of dependent
<p>Short Term Disability Income (Post-Tax)</p> <input type="checkbox"/> Terminate coverage <input type="checkbox"/> Start coverage (evidence of insurability and election forms must be completed)	<p>Group Medical Insurance (Pre-Tax) (Please submit health insurance status change form)</p> <input type="checkbox"/> Terminate <input type="checkbox"/> Change to single coverage <input type="checkbox"/> Change to Employee + Child(ren) <input type="checkbox"/> Change to Employee + Spouse <input type="checkbox"/> Change to family coverage <input type="checkbox"/> 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 <https://www8.miamidade.gov/global/humanresources/benefits/home.page>. 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.