

**THE UNIVERSITY OF TEXAS SYSTEM
EMPLOYEE GROUP INSURANCE PROGRAM**

CHANGE IN STATUS FORM FOR MID-YEAR BENEFIT ELECTION CHANGES

Treas. Reg. §1.125 prohibits changing your employee benefit elections mid-plan year (September 1 through August 31) unless one or more of the events described as a “Change in Status” has occurred. To make a change in your employee benefit elections outside of the usual Annual Enrollment period, you must meet one or more of the criteria listed below.

In addition, the change you request must be consistent with your qualified Change in Status event. If your requested change is not consistent with your Change in Status or your requested change does not fall within a category listed below, your request will be disapproved.

IMPORTANT: You have 31 days following the date of the qualifying event to submit this form to your benefits office. If this form is not received by your benefits office within 31 days, your request will be disapproved and you will have to wait until the next Annual Enrollment to apply to make the change. Evidence of Insurability (EOI) may be required.

SECTION I: CHANGE IN STATUS EVENTS AND COST OR COVERAGE CHANGES		DATE OF THE EVENT (mm/dd/yyyy)
Please check all that apply and provide the date of the event.		
<input type="checkbox"/>	Change in Your Marital Status due to marriage, divorce, annulment, legal separation, or spouse’s death	
<input type="checkbox"/>	Change in Number of Your Dependent Children due to birth, adoption, placement for adoption, death, or dependent child(ren)’s arrival to (or departure from) the United States	
<input type="checkbox"/>	Change in Residence that causes you, your spouse, or your dependent child(ren) to no longer be eligible for the plan originally selected	
<input type="checkbox"/>	Change in Employment Status such as changing from full-time to part-time employment, starting new employment, ending employment, returning from unpaid leave of absence, beginning your retirement, or other changes that affect plan eligibility (Note: To drop coverage, proof of other insurance enrollment must be provided.)	
<input type="checkbox"/>	Change in Dependent Eligibility such as marriage or divorce of your dependent child, or your dependent child attaining 25 years of age	
<input type="checkbox"/>	Cost Changes such as a mid-year increase (or decrease) in your benefit plan’s rates that causes you to have a significant increase (or decrease) in cost	
<input type="checkbox"/>	Coverage Changes: Significant Improvement or Curtailment of Benefit Package Option (With or Without Loss of Coverage) such as the addition of a new plan option, or the elimination or significant reduction of a plan benefit	
<input type="checkbox"/>	Change in Coverage Under Other Employer’s Plan such as a change in your spouse’s or dependent child’s benefits plan	
<input type="checkbox"/>	Loss of Coverage Under Certain Group Health Plans of Government or Educational Institutions such as a state children’s health insurance program (CHIP), state health benefits risk pool, or foreign government group health plan	
<input type="checkbox"/>	FMLA Leave If you are an employee taking leave under the Family and Medical Leave Act (FMLA), you may revoke an existing election and make other elections for the remaining portion of the coverage period under FMLA.	
<input type="checkbox"/>	COBRA Events such as your spouse or dependent child becoming eligible for continuation of coverage under a group health plan due to termination of your employment, divorce, legal separation, or dependent child reaching age 25	
<input type="checkbox"/>	Court Judgment, Decree, or Order from a legal separation, divorce, annulment, or change in custody that requires your dependent child to be covered under a group health plan	
<input type="checkbox"/>	Medicare or Medicaid Entitlement , such as you, your spouse or your dependent child with medical coverage becoming eligible (or losing eligibility) under Medicare or Medicaid. This change applies to all qualified benefits except the UT FLEX Dependent Care Reimbursement Account.	

SECTION II: BENEFIT PLAN CHANGES

Place a check mark beside each benefit change you request.

HEALTH BENEFITS

- Add Dependent(s)
- Remove Dependent(s)
- Add Coverage
- Drop Coverage
- Change Plans (if applicable)

LIFE INSURANCE AND/OR PERSONAL ACCIDENT INSURANCE

- Add Dependent(s)
- Remove Dependent(s)
- Change Level of Coverage
- Change Amount of Coverage
- Drop Coverage
- Change Plans (if applicable)

DENTAL

- Add Dependent(s)
- Remove Dependent(s)
- Add Coverage
- Drop Coverage
- Change Plan (if applicable)

VISION

- Add Dependent(s)
- Remove Dependent(s)
- Add Coverage
- Drop Coverage

LONG TERM DISABILITY

- Add Coverage
- Drop Coverage

LONG TERM CARE

- Add Coverage
- Drop Coverage

UT FLEX

- Medical Expense Reimbursement Account**
- Dependent Care Reimbursement Account**
- Change Election Amount
- Change Election Amount
- Cancel Election Amount
- Cancel Election Amount

IMPORTANT: I understand I will be required to provide the appropriate documentation for any of the changes I have requested above. I attest that the change requested is made as a result of and corresponds with the Change in Status event. Before I am allowed to drop coverage, I understand that I will be required to show proof of actual enrollment in a new outside plan. In addition, I am aware that completion of this form does not finalize my election change, and my benefits office will require that I complete an application form and additional forms, as needed, before my benefit changes are complete. I also understand that if my dependents were previously eligible under these plans, Evidence of Insurability (EOI) will be required.

Employee Signature _____
Print Name / /
MM / DD / YYYY
Date Signed

	<i>This Section for Benefits Office Use Only</i>	
<u> </u> / <u> </u> / <u> </u> MM / DD / YYYY		Approved _____
Date Change In Status Form Received		Declined _____
_____	_____	<u> </u> / <u> </u> / <u> </u>
Benefits Office Signature	Print Name	MM / DD / YYYY
		Date Signed