



# Family Status Change Form

Employees who enroll in the medical, dental and/or vision coverage offered by eFunds cannot enroll or cancel their participation in a plan during the year except during an open enrollment period, or in the event of an IRS approved family status change (Section 125, Regulation 1.25-2). **Notification and evidence of the Family Status Change must be received by the Benefits Department within 31 days of the life event defined as a Family Status Change. If it is not, no changes will be permitted to your benefits, per IRS guidelines.**

Examples of approved family status changes are; marriage, death, divorce, birth/adoption of a child, or the loss or gain of other health coverage through other employment. The coverage change must relate directly to the status change. Please select the Type of Family Status Change you are requesting from the list below. The supporting documentation must be provided with the Family Status Change form.

- | <u>Supporting documentation</u>                |   |
|--|---|
| <input type="checkbox"/> Marriage              | Marriage certificate  |
| <input type="checkbox"/> Divorce               | Divorce decree  |
| <input type="checkbox"/> Death                 | Death certificate   |
| <input type="checkbox"/> Loss of Coverage      | Certificate of portability statement - <i>OR</i> -COBRA letter from previous employer |
| <input type="checkbox"/> Gain of Coverage      | Letter from new employer on their letterhead, stating the new coverage effective date |
| <input type="checkbox"/> Birth of child        | Copy of birth registration form from hospital   |
| <input type="checkbox"/> Adoption of child     | Adoption certificate  |
| <input type="checkbox"/> Move                  | Date of move and new address  |
| <input type="checkbox"/> Dependent Ineligible  | Dependent graduated; dependent dropped out of school                                  |
| <input type="checkbox"/> Add Student Dependent | Add a student dependent (age 19 to 25) to your coverage                               |

To report a family status change, complete and mail this form *AND* the required documentation to the Benefits Department at: Gainey Center II, Suite 300, 8501 North Scottsdale Road, Scottsdale, AZ 85253.

The effective date of coverage can be the date of the family status change *OR* the 1<sup>st</sup> of the month following the family status change. **Please remember that all documentation must be received by the benefits department within 31 days of the family change.**

Personal Data										
Date of Event:		Birth Date:		Last name, First name, Middle Initial:						
Social Security Number:		Work Location		Work Phone #		Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time				
Dependent Information: Complete only if adding or deleting dependents for current plan year										
Check One		First Name, Middle Initial, Last Name	Disabled	Student	Sex	Birth Date			Relation (Circle One)	Social Security Number
Add	Del					M	D	Y		
									Child Spouse Dom. Partner Child of Dom. Partner	
									Child Spouse Dom. Partner Child of Dom. Partner	
									Child Spouse Dom. Partner Child of Dom. Partner	
									Child Spouse Dom. Partner Child of Dom. Partner	
									Child Spouse Dom. Partner Child of Dom. Partner	

## Benefit Information

An Affidavit for Domestic Partnership required for approval in order to add a domestic partner, and children if applicable, to any benefit elected. The affidavit must be received within 31 days of your hire date. If this affidavit is not received by the deadline, your domestic partner (and children if applicable) will not be added to your coverage.

<b>Medical:</b> <input type="checkbox"/> Elect <input type="checkbox"/> Waive/no waiver premium (for eFunds associates covered by another eFunds associate) <input type="checkbox"/> Waive/Collect Waiver Premium	<input type="checkbox"/> PPO-High Option <input type="checkbox"/> PPO-Middle Option <input type="checkbox"/> PPO-Low Option <input type="checkbox"/> HMO The HMO is available to Minnesota residents only.	<input type="checkbox"/> Employee <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child <input type="checkbox"/> Employee+Family
<b>Dental:</b> <input type="checkbox"/> Elect <input type="checkbox"/> Waive <input type="checkbox"/> Proof Provided with waive	<input type="checkbox"/> Employee <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child <input type="checkbox"/> Employee+Family	
<b>Vision:</b> <input type="checkbox"/> Elect <input type="checkbox"/> Waive	<input type="checkbox"/> Employee <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child <input type="checkbox"/> Employee+Family	
<b>LTD (default):</b> (Company paid)  <input type="checkbox"/> Elect	<input type="checkbox"/> Pretax (default) <input type="checkbox"/> Post tax (EE pays tax on company cost)	
<b>Dependent Care Reimbursement Account:</b> Annual Max. \$5,000  <input type="checkbox"/> Elect Annual Amount: _____ <input type="checkbox"/> Waive	<b>Health Care Reimbursement Account:</b> Annual Max. \$5,000  <input type="checkbox"/> Elect Annual Amount: _____ <input type="checkbox"/> Waive	
<b>Legal:</b> \$180 annual, \$15 a month <input type="checkbox"/> Elect <input type="checkbox"/> Waive		
<b>SIGNATURE</b>		<b>DATE</b>
<p>By signature, I elect to participate in the Plan, and I authorize the Company to reduce my compensation by the amount required to pay my share of the premiums for the coverage that I have elected. These payroll contributions will be taken on a pre-tax basis, unless otherwise noted. I understand that these elections are irrevocable for the remainder of the plan year unless I experience a Family Status Change as outlined in our benefit materials. A summary of the plan has been made available to me. I have read and understand the important information in the summary and the information presented in this application. I further understand that any salary reduction I have elected reduces my compensation for Social Security purposes and that my Social Security benefits could be decreased because of such decreased amount of compensation. While it is the intent of the Employer to maintain this Plan, the Employer reserves the right to terminate or amend the Plan in any manner, at any time.</p>		

If you waive medical and/or dental coverage and wish to receive money back under the eFunds plan, you will be required to provide confirmation of existing coverage. Confirmation of existing coverage under another employer's plan, must be sent to the Benefits Department on letterhead from the Company providing insurance or a copy of your current medical/dental card. **This documentation must be within 31 days of the event.** If it is not, you will forfeit your right to collect the waiver premium.