2019 QUALIFYING EVENT FORM for Part-time & PRN Employees

EMPLOYEE INFORMATION - Please provide all information

Employee Name:	Employee ID #:	Employee Address:

☐ **Employee Name Change** — **Phone #:**

Current Name:

Requested Name Change:

☐ Loss of Other Coverage ☐ Marriage ☐ Birth, Adoption or Placement for Adoption ☐ Become eligible for CHIP or Medicaid

☐ Gain of Other Coverage ☐ Divorce or Legal Separation ☐ Death of Spouse or Child ☐ Become eligible for State Premium Assistance

☐ Other

ENROLL IN BENEFITS

MEDICAL BENEFITS

Part-time & PRN Non-Nicotine Medical Rates		Part-time & PRN Nicotine Rates Medical Rates			
☐ Employee Only	$94.00	☐ Employee Only	$122.20		
☐ Employee + Spouse	$196.00	☐ Employee + Spouse	$254.80		
☐ Employee + Child(ren)	$170.00	☐ Employee + Child(ren)	$221.00		
☐ Employee + Family	$281.00	☐ Employee + Family	$365.30		

☐ Waive Medical Coverage

DEPENDENT INFORMATION

Dependent Name	Relationship	Gender	Date of Birth	Social Security Number

EMPLOYEE SIGNATURE DATE