Change in Status/Special Enrollment Request Form

For use in processing Qualifying Events: benefits election changes, adding and/or dropping dependents.
Must be submitted within 60 days from the date of the event.

Please fax signed copy and supporting documentation to: **(866) 616-8858** or email to: **ESC@ADP.com**

EMPLOYEE INFORMATION

Name:		**Worksite Employer Name:**	
Address:		**City, State**	**Zip Code**
SS#:	**Birth Date:**	**Gender:** ☐ **Male** ☐ **Female**	**DATE OF EVENT:**
Email:		**Best Number to call:**	

IMPORTANT INFORMATION

Notification Requirement & Effective Date

ADP TotalSource must receive your completed enrollment request and supporting documentation if you experience a change-in-status or special enrollment **within 60 days of the event** otherwise you will not be permitted to make benefit elections changes until the next Open Enrollment (i.e., June 1st). **Please note that this request will not be processed without the proper proof of status change documentation** (examples provided within the Status Change Information section of this form). The documentation must contain the employee and/or dependent's name along with the date of event or eligibility. You should contact the Employee Service Center at (800) 554-1802, if you are not sure what documentation is acceptable for your change in status.

All approved benefit election changes as a result of a qualified change in status will become **effective on the first day of the month following ADP TotalSource's receipt of your completed enrollment form and proof of change in status**. However, in the event of a birth, adoption, or placement for adoption the new dependent will be added retroactive to the date of birth, adoption, or placement for adoption.

Note: If you have experienced a change in status event whereby you or your dependent have gained other group health, dental or vision coverage and are requesting to drop coverage, please complete the ***Certification of Other Group Health, Dental, Vision Plan Coverage*** form and submit it along with the completed Change in Status Form.

Change in Status Consistency Rules

Due to IRS regulations, your enrollment changes must be consistent with your qualified change-in-status. ADP TotalSource will advise you if your request for an enrollment change is not consistent with these rules. The Employee Service Center (ESC) or your human resource representative can assist you in determining what election changes satisfy the IRS consistency rule. Any application of a permissive Change-in-Status rule will conform to consistency requirements under the regulation and to the terms of any applicable insurance policy, including any HMO contracts where applicable. Please refer to the Summary Plan Description for further details.

STATUS CHANGE INFORMATION

Place a ☑ in the box below that corresponds to your change in status event. **Proof of your change in status or special enrollment event is required.** Please refer to the list of ***Acceptable Documentation*** options for each of the corresponding Events below.

Event	*Acceptable Documentation*	*Event*	*Acceptable Documentation*
❑ Marriage of employee	Marriage certificate or license (if adding spouse and/or dependents)	❑ Legal Separation	Court Order of legal separation
❑ Birth of child	Birth certificate or hospital certificate	❑ Divorce	Divorce decree
❑ Change in Dependent Employment	Letter on employer letterhead with start or end date of benefits eligibility or Certification of Other Coverage	❑ Qualified Medical Child Support Order (QMCSO)	Written notice from govt. agency
❑ Change in Dependent Eligibility	Certification of eligibility if 26 or over	❑ CHIPRA	Written notice from govt. agency
❑ Adoption / Legal Guardianship	Court documentation of adoption or legal guardianship	❑ Change in Residence	Proof of new address (utility bill, lease agreement, etc.)
❑ Placement for Adoption	Agency Certification of placement	❑ Medicare or Medicaid Entitlement	Notice from govt. agency or ID Card
❑ Death of Dependent	Death certificate or funeral home/burial certification	❑ Loss of other health coverage (Special Enrollment)	Creditable coverage certificate or letter on employer letterhead
❑ Family Medical Leave	Per FMLA dept. guidelines	❑ Open Enrollment for dependent	OE documentation with effective or termination date or ID card or Certification of Other Coverage
❑ Other:			

ADP TotalSource
Bottom Line. Your team just got better.™

Change in Status/Special Enrollment Request Form

DEPENDENT INFORMATION: Check ☑ the appropriate action box (Add or Remove) for the Medical, Dental and Vision Plan.
If you are adding a dependent to an HMO, POS, or DMO plan, you must include the PCP ID number.
***Please note HIPAA Special Enrollment periods only apply to the Medical Plan. Refer to the Summary Plan Description for further details.**

LAST NAME, FIRST NAME	DATE OF BIRTH	RELATION	SOCIAL SECURITY #	MEDICAL Check ☑ One	DENTAL* Check ☑ One	VISION* Check ☑ One
		Employee		❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove
				❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove
				❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove
				❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove
				❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove
				❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove
				❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove
				❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove ☐ PCP#:	❒ Add ❒ Remove

MEDICAL REIMBURSEMENT ACCOUNT*

❑ I wish to enroll. **Annual** Election $________________

❑ I wish to ❑ increase or ❑ decrease my annual contribution. New **Annual** Election $________________

DEPENDENT CARE REIMBURSEMENT ACCOUNT*

❑ I wish to enroll. ❑ I wish to cancel. **Annual** Election $________________

❑ I wish to ❑ increase or ❑ decrease my annual contribution. New **Annual** Election $________________

HEALTH SAVINGS ACCOUNT (HSA) – Note: Changes to your HSA elections are permitted throughout the plan year without restrictions.

❑ I wish to ❑ increase or ❑ decrease my monthly HSA contribution. New **Monthly** Election $________________

❑ I wish to stop my HSA deductions.

HIPAA Special Enrollment Rights – Loss of other coverage

The HIPAA special enrollment period only applies to Medical Plans, therefore, you may only make changes to your medical plan election (changes to dental, vision, FSA or life elections are not permitted). The following conditions are required to qualify for a Special Enrollment due to a loss of other health coverage:

1. You were covered under another group heath Plan or other heath insurance when the Medical Plan was first offered to you; and
2. You indicated on the ADP TotalSource Health and Welfare Plan enrollment form that you declined Medical Plan enrollment because you had other medical Plan coverage; and
3. If you declined to enroll in the ADP TotalSource Medical Plan because you decided you wanted to continue COBRA as the only coverage, your COBRA coverage period has expired for reasons other than your failure to pay COBRA premium.

AUTHORIZATION

I authorize the action(s) I have indicated on this form as well as necessary payroll deduction changes and understand that any request to change my current ADP TotalSource Health and Welfare Benefits elections will require proper documentation and **must be submitted within 60 days** from the date of the event. I hereby certify that the above information is complete and accurate.

If you live in California and enroll in a Health Plan that uses binding arbitration to settle disputes, the following acknowledgement will apply:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and benefits claims subject to Erisa) any dispute between myself, my heirs or other associated parties on the one hand and Health plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Subject to the three exceptions noted above, I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Health Plan's Evidence of Coverage.

______________________________ Signature

______________________________ Date

Please submit your completed form and proof documentation to:
Fax: (866) 616-8858
Email: ESC@ADP.com

Certification of Other Group Health, Dental, Vision Plan Coverage

INSTRUCTIONS: If you or your dependent(s) have experienced a change in status event whereby you have gained other group health, dental or vision coverage please complete this form and fax or email it back along with the Change in Status Form.

I, _____ *(Name of Employee)*, submit this Certification of Other Group Health, Dental, Vision Plan Coverage in support of my request to change benefit elections based on a marital or employment change in status under the ADP TotalSource, Inc. Health and Welfare Plan (the "Plan").

I certify that the individuals listed below currently have medical, dental and/or vision coverage under the Plan, and that I now wish to drop Plan coverage for these individuals because they have obtained other **group** ___medical ___dental ___vision plan coverage effective _____ due to the following change in status event :

_____Change in employee's legal marital status

_____Change in employment status of a spouse or dependent that affects eligibility

_____Open Enrollment under spouse or dependent's employer plan

I understand that obtaining "individual" health plan or health insurance coverage in connection with a marriage or change of employment does not satisfy the IRS change-in-status rules, and certify that the other health, dental or vision plan coverage obtained by the below named individuals is provided through another employer.

I understand that once I drop Plan coverage for myself and/or for one or more of my dependents (including a spouse, a domestic partner, or dependent children), I may not reenroll myself or my dependents for Plan coverage until the next annual open enrollment period or, if earlier, the occurrence of a qualified change-in-status that permits me to reenroll myself and/or my dependents.

I understand that providing false or misleading information in this Certification may result in loss of Plan enrollment, termination of my employment and other legal action against me.

(List the names of the individuals for whom coverage under the Plan is being dropped because they have obtained other group health plan coverage)

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

I, _____, of full age, upon my oath, hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are false or misleading, I am subject to loss of Plan enrollment, termination of employment, and other legal sanctions.

_____ _____ _____
Signature of Employee Employee ID Number Date

_____ _____
Client Name Paygroup

FAX OR EMAIL COMPLETED FORM TO:
Fax: (866) 616-8858
Email: ESC@ADP.com