QUALIFYING LIFE EVENT CHANGE FORM

Name _____ SS# _____

Home Address _____ City, State _____ Zip _____

Date of Birth _____ Email _____

Work # _____ Cell # _____ Job Title _____

Date of Qualifying Life Event _____ Effective Date _____

Type of Qualifying Life Event:

☐ Birth/ Adoption/ Guardianship ☐ Marriage ☐ Divorce ☐ Death ☐ Loss or Gain of Coverage

☐ Other _____

Dependent Information

First Name	Last Name	Date of Birth	Gender	Relationship to Employee

Beneficiary Information

First Name	Last Name	Date of Birth	Relationship to Employee	Secondary or Primary	Percentage

DENTAL COVERAGE (DELTA DENTAL)

MONTHLY RATES	LOW PLAN	HIGH PLAN
Employee	☐ $0.00	☐ $12.10
Employee + Spouse	☐ $17.17	☐ $45.00
Employee + Child(ren)	☐ $28.76	☐ $55.82
Family	☐ $37.92	☐ $76.48
Decline	☐ $0.00	☐ $0.00

VISION COVERAGE (EYEMED)

COVERAGE TIER	MONTHLY RATES
Employee	☐ $8.78
Employee + Spouse	☐ $16.68
Employee + Child(ren)	☐ $17.56
Family	☐ $25.81
Decline	☐ $0.00

Signature _____ Date _____