Henrico County Department of Human Resources – General Government
Qualifying Event Form

We must receive this form and your Enrollment/Change form(s) within 60 calendar days of the event
Effective dates of coverage will be determined by the specific event as defined below.

Employee Name (please print): _____ Phone # _____

SSN or Employee ID #:_____ Date of Event: _____

Enrollment for these events is effective the date of event: **HIPAA SPECIAL ENROLLMENT**

☐ Birth, Adoption, or Placement for Adoption – *Provide documentation of birth date or copy of the adoption decree or pre-adoptive placement agreement.*

Removal of an ineligible dependent is effective at the end of the month in which they become ineligible:

COBRA QUALIFYING EVENTS

☐ Divorce – *Copy of final divorce decree must be attached*
Provide address of former spouse: _____
_____
_____

☐ Child no longer eligible dependent (age 26)
Provide child's address, if different: _____
_____
_____

☐ Death of spouse or child - *Provide documentation of date of death*.

Changes for the following events (addition or dropping of coverage must be consistent with applicable event) are effective the first of the month following receipt of your request or following the event, whichever is later:

SECTION 125 STATUS CHANGES

☐ Marriage - *Copy of marriage certificate must be attached.*

☐ Custody or guardianship – *Attach copy of custody order.*

☐ Change in your employment status from part-time to full-time

☐ Change in your employment status from full-time to part-time

☐ Change in your employment status from paid status to leave without pay

☐ Change in your employment status from leave without pay to paid status

☐ Change in eligibility for Medicare, Medicaid, or State CHIP program, including subsidy eligibility
You have a 60-day HIPAA special enrollment for these events.

☐ Change of spouse's or dependent's employment status - *See attached page for documentation needed*.
Benefit Eligibility Change Date:_____

☐ Significant change in spouse's or dependent's employer provided coverage – See attached page for documentation needed.
(Note: This event is not a qualifying event for Health Care Flexible Spending Account changes.)

☐ Spouse's or dependent's employer has a different Open Enrollment period and Plan Year
Date of coverage change for employer-provided plan: _____
See attached page for documentation needed
(Note: This event is not a qualifying event for Health Care Flexible Spending Account changes.)

☐ Loss of coverage due to: _____
See attached page for documentation needed.

☐ Other_____

I certify that the information above is correct and in accordance with the County of Henrico Health Plan document.

Employee Signature: _____ Date: _____

Qualifying Events
Additional Documentation

Benefit changes must be on account of and consistent with the event.

Qualifying Event	**Documentation Needed**
Change of spouse's or dependent's employment status	HIPAA Certificate from former plan **OR** Letter on employer's letterhead stating: • Date letter is prepared • Name of employee and covered dependents • Name of employer providing coverage • Type of coverage (Health and/or Dental) • Date coverage ended (if adding spouse/children to County coverage) OR Date coverage will begin (if dropping spouse/children from County coverage) • Name of carrier • Employer contact name, phone number, address
Significant change in spouse's or dependent's employer-provided coverage	Letter on employer's letterhead stating: • Date prepared • Name of employer providing coverage • Type of coverage (Health and/or Dental) • Name of employee and covered dependents • Name of current carrier • Description of significant change in coverage • Effective date of significant change in coverage • Employer contact name, phone number, address
Spouse's or dependent's employer has a different Open Enrollment period and Plan Year from the County's	Letter on employer's letterhead stating: • Date letter is prepared • Name of Spouse's or dependent's employer • Type of coverage (Health and/or Dental) • Name of dependents changing coverage • Date coverage change is effective • Employer contact name, phone number, address
Loss of coverage	HIPAA Certificate from former plan **OR** Letter on prior employer's letterhead stating: • Date letter is prepared • Name of employer that provided coverage • Type of coverage (Health and/or Dental) • Name of employee and dependents losing coverage • Date coverage ends • Name of prior carrier • Employer contact name, phone number, address

Eligible Dependents

Spouse – legal marital relationship

Child – natural, adopted, step, legal guardianship, legal custody, proposed adoption, under age 26 (unless Totally Disabled)

Letters may be addressed to the employee OR to:

Henrico County Department of Human Resources
Benefits Division
P.O. Box 90775
Henrico, VA 23273-0775
Phone (804) 501-7371 Fax (804) 501-4426