SCHOOL DISTRICT OF MENOMONEE FALLS
W156 N8480 Pilgrim Rd ◇ Menomonee Falls, WI 53051
Ph. 262-255-8396 ◇ Fax. 262-255-8461

BENEFIT ELECTION CHANGE FORM

Full Name: ____

Address: ____

____

Phone #: ____

Effective Date of Change: ______________________________

Instructions

Check the appropriate box to indicate a Change in Status or a Change in Cost or Coverage that may qualify you to change your coverage election for the Plan Year. ***A qualifying event does not allow you to change your health plan design, unless you are enrolling new to the health coverage as the employee due to the event.*** **If you are unsure if an event qualifies, please refer to our plan documents.**

Change in Marital Status: ☐ Marriage ☐ Divorce ☐ ☐ Death of Spouse ☐ Legal Separation

Change in Number of Tax Dependents: ☐ Birth ☐ Placement for Adoption ☐ Adoption ☐ Death of Dependent

Change in Employment Status that Affects Eligibility:	You	Spouse/Dependent
Termination of Employment..	☐	☐
Part-time to Full-time...	☐	☐
Full-time to Part-time...	☐	☐
Commencement of Employment...................................	☐	☐
Return from unpaid leave of absence............................	☐	☐
Change in Spouse/Dependent Eligibility under an Employer's Plan............		☐
Change in Residence Affecting Eligibility....................................	☐	☐
Loss of Coverage due to: ____________________________	☐	☐

Changes in Cost or Coverage
(Note: Changes in cost or coverage do not allow for changes to health FSA's)
Please specify:____

Other: ____

I understand that I must provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with my employer's plan and the Plan Administrator has sole discretion to make this determination.

Employee Signature: ______________________________ **Date:** __________________

Participant Information

List all Enrolling/Changing/Cancelling (Attach additional sheet if necessary). Please Print.

Last Name			First Name		MI
Social Security #	Date of Birth / /	Gender M F	Relationship	Full-time Student Y N	
Cancel: (circle)	Medical Dental Vision	Enroll: (circle)	Medical Dental Vision		

Last Name			First Name		MI
Social Security #	Date of Birth / /	Gender M F	Relationship	Full-time Student Y N	
Cancel: (circle)	Medical Dental Vision	Enroll: (circle)	Medical Dental Vision		

Last Name			First Name		MI
Social Security #	Date of Birth / /	Gender M F	Relationship	Full-time Student Y N	
Cancel: (circle)	Medical Dental Vision	Enroll: (circle)	Medical Dental Vision		

Last Name			First Name		MI
Social Security #	Date of Birth / /	Gender M F	Relationship	Full-time Student Y N	
Cancel: (circle)	Medical Dental Vision	Enroll: (circle)	Medical Dental Vision		

I understand that if waiving coverage at this time, I will not be allowed to participate unless I experience a qualifying event or at the next open enrollment period, if applicable. This statement also applies to family members that I did not enroll even though I was eligible for family insurance. If I, or a family member, experience a qualifying event that qualifies me/us for coverage, I must apply no later than 30 days from the qualifying event. Enrollment of a family member requires that I am also enrolled in the benefit.

Acceptance of Coverage Change:

Sign:_______________________________________ Date: _________________________