IRS Section 125 Qualifying Event Checklist

-Flexed Premiums & Un-reimbursed Medical-

CWID# _____ - ____ - _____ Employee Name: _____ Date: _____

ALL CHANGES ARE EFFECTIVE THE FIRST OF THE FOLLOWING MONTH AND CHANGES REQUESTED MUST BE SUBMITTED WITHIN 30 DAYS OF THE QUALIFYING EVENT

THE FOLLOWING MUST BE COMPLETED:

This Qualifying Event must be ***consistent*** with the request to add, drop, or make a change affecting your tax-sheltered health, dental, or vision premiums and Flexible Spending Account. **Please explain the qualifying event(s) and describe how the requested change is consistent with the event(s):**

_____

_____

_____

(Example: spouse changed jobs, lost health benefits with previous employer, coverage ended 7/31/11, add spouse to health 8/1/11.)

✓ Change	**Change in Legal Marital Status**	**Date of Event**	**Name of Spouse**
	Marriage (excludes common-law)		
	Divorce/Legal Separation/Annulment (circle as appropriate)		
	Death of Spouse		
✓ Change	**Change in Number of Dependents**	**Date of Event**	**Name of Dependent**
	**Birth		
	Adoption/Placement for Adoption		
	Death		
	Gain/Loss of Group Student Health Insurance School Name:_____ Group Student Insurance Plan Name:_____		
✓ Change	**Change in Employment Status: (circle affected) Employee / Spouse / Dependent**	**Date of Change**	**Name of Spouse/Dependent**
	Leave of Absence (going on or returning from LTD, LWOP, Military, Layoff & FMLA)		
	Terminate/rehire within 30 days (re-instate original election)		
✓ Change	***Gain/Loss of Coverage: (circle affected) Employee / Spouse / Dependent**	**Gain/Loss Date**	**Name of Individual(s)**
	*Gain of Coverage: Health Dental Vision Employer/State Sponsored Plan Name:_____ Ins. Co.:_____Policy#_____		
	*Involuntary Loss of Coverage: Health Dental Vision Employer/State Sponsored Plan Name:_____ Ins. Co.:_____ Policy#_____		
	Cancellation/Commencement of coverage: Medicare Medicaid SoonerCare		
✓ Change	**Change in Status Affecting Dependent Eligibility:**	**Date of Event**	**Name of Dependent**
	Attained age 26		
✓ Change	**Change in Residence affecting DMO:** (must live or work within zip code area) Current Vendor:	**Date of Move**	**Name of Individual(s)**
✓ Change	**Change of Custody, Judgment, Court Order or Decree** requiring	**Date of Order**	**Name of Dependent(s)**
	Health coverage, including Qualified Medical Child Support Orders (QMCSO): Employee must have court order to cover a dependent child(ren), changes must be consistent with order.		

*Mid-year changes are allowed when gaining or losing coverage through a spouse's employer, your former employer, group student health coverage, or one of the federal or state sponsored insurance plans (i.e. COBRA, Military, Indian Health, Medicare, Medicaid, SSA, Veteran's Administration). Mid-year changes are not allowed for a voluntary drop of coverage. Mid-year changes may be subject to pre-existing condition exclusions. **Changes due to the birth of a child are retroactive to the date of birth, unless noted. If birth occurs the 15th of the month or before, premiums will be due the 1st of that month. If birth occurs after the 15th of the month, premiums will not be due until the 1st of the following month.

Employee Signature: _____

Your signature confirms that all statements herein are true. Documentation that authenticates these statements could be required during an audit. Refer to Title 74 Oklahoma Statutes § 1323, Fraud – Penalties