BAY COUNTY SCHOOL BOARD
IRS Section 125 Qualifying Events Checklist and Change Form

In order to make changes that affect your pre-tax medical, dental or vision premiums, you will need to indicate in the appropriate box the qualifying event that is consistent with such a change. The same requirements apply to changes in your Flexible Spending Account for either your un-reimbursed medical account or dependent care account.

All changes must be made within 30 days of the qualifying event. Original document is required for processing and must be received in the office of the Insurance Department within the 30 day time frame.

First Name:	Last Name:	MI:	EMP ID#:
Street Address:			
City:	State:	Zip:	Phone:

Please explain the qualifying event and describe the requested change:

(Example: Spouse changed jobs, health coverage with previous employer ends 3/31/11 add to health coverage 4/1/11.)

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This Qualifying Event must be consistent with the request to add, drop or make a change that affects your pre-tax heath, dental, or vision premiums and Flexible Spending Account for your un-reimbursed medical account.

	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 in Number of Dependents	**Date of Event**	**Name of Dependent**
☐	Birth		
☐	Adoption/Placement for Adoption		
☐	Death		
	Change in Employment Status: Employee / Spouse / Dependent	**Date of Change**	**Name of Dependent**
☐	Termination of Employment - Loss of Employers Group Coverage Employer Name: Ins. Co. Policy #		
☐	Commencement of Employment - Gain of Employer Group Coverage Employer Name: Ins. Co. Policy #		
☐	Leave of Absence (going on or returning from)		
☐	Commencement of Unpaid Leave (Extended, FMLA & Military)		
☐	Terminate/rehire **within** 30 days (reinstate original election)		
	***Gain/Loss of Coverage: Employee / Spouse / Dependent**	**Gain/Loss Date**	**Name of affected individuals**
☐	* Gain of Coverage: (circle appropriate) Health Dental Vision Employer Name: Ins. Co. Medicare Policy #		
☐	* Involuntary Loss of Coverage: (circle appropriate) Health Dental Vision Employer/State Sponsored Plan Name: Ins. Co. Policy #		
☐	Cancellation/Commencement of Coverage: Medicare Medicaid		

	Change in Status affecting Dependent Eligibility:	Date of Event	Name of Dependent
☐	Attained Maximum Age Health 26 Dental 25/30 Vision 25		
☐	Marriage		
☐	No longer a dependent		
	Change of Custody, Judgment, Court Order or Decree	**Date of Order**	**Name of Dependent**
☐	Health coverage, including Qualified Medical Child Support Orders (QMCSO): If employee has court order to cover dependent child(ren), changes must be consistent with the order.		

* Mid-year changes are allowed when gaining or losing coverage through a spouse's employer, your former employer, or one of the federal or state sponsored insurance plans (ie COBRA, military, Medicare, Medicaid). Mid-year changes are not permitted for a voluntary cancellation of coverage.

Employee's Signature & Date		
Your signature confirms that all statements herein are true and accurate. Documentation that authenticates these statements could be required during an audit.		
Printed Name:	EMPLOYEE ID:	
Signature:	DATE:	