Wheaton College

Change in Status Form

Application for Change in Election

Directions: If you wish to make a change in your benefits election, other than during a regular Open Enrollment period, and you currently have or want deductions taken pre-tax, you must complete this form, along with a new provider application form (if applicable), and submit them within 30 days of the event to Human Resources for approval. Completion of this form in no way guarantees benefits.

I. Background Information – *Please print clearly*

A. Name

_______________________________ _______________________ **W #** ________________

(Last) (First)

B. Spouse's Name

_______________________________ _______________________

(Last) (First)

C. Spouse's Employer

____ (_______) - _______ - __________

(Employer's Name) (Phone Number)

II. Change in Status (under pre-tax rules)

Description of Event: Only the events listed below may be considered when making changes to your medical and/or dental election. Please indicate below (check one) the change in status for which you are requesting a new election under the Wheaton Medical and/or Dental Program.

Effective date of enrollment or termination in health and/or dental plan(s): ________ / ________ / ________
(Please note that this form must be submitted within 30 days of the above date.)

- ☐ Marriage
- ☐ Divorce/Annulment
- ☐ Legal separation
- ☐ Death of Spouse/Dependent
- ☐ Birth of Child
- ☐ Adoption of Child
- ☐ Begin or end Unpaid Leave (Employee/Spouse)
- ☐ Change in residence (Employee/Spouse/Dependent)
- ☐ Change in benefit eligibility (Employee/Spouse/Dependent)
- ☐ Spouse/Dependent terminated employment
- ☐ Spouse/Dependent commenced employment
- ☐ Spouse experienced significant change in cost/coverage (see reverse side)
- ☐ Dependent Child(ren) turning 19 or graduating from college
- ☐ Qualified for loss of Medicare or Medicaid (Employee/Spouse/Dependent)

III. New Election Statement

I have read and understand the description of the Wheaton Medical and Dental Program. I understand that any change in my Election during the Plan Year is subject to the requirements of the Internal Revenue Code and the approval of the Administrator of the Plan. I certify that the above change in status has occurred, and that the information provided, to the best of my knowledge and belief, is correct and complete.

Signature: ____ **Date:** ______ / ______ / _______

For Human Resources Only:
☐ **Approved** ☐ **Not Approved** **by:** ______________________________ **Date:** ______ / ______ / _______

☐ Pre-tax ☐ Post-tax

IMPORTANT ADDITIONAL INFORMATION

Significant Change: *A "significant change" means the contribution cost of your spouse's health/dental plan has increased or decreased by 10% or more, or there has been a significant change in plan coverage. If significant change is related to cost, please attach* **written documentation** *of your spouse's: 1) previous health/dental election; 2) both old* ***and*** *new medical/dental contribution costs; and 3) the effective date of this change in cost. If significant change is related to plan coverage, please attach documentation from spouse's employer.*

Additional Comments:

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