

# QUALIFIED LIFE EVENT BENEFITS ENROLLMENT FOR EMPLOYEES WITH OPPOSITE SEX DOMESTIC PARTNERS

**Qualified Life Events (see page 4) must be filed within 31 days after a qualified life event.**

Please follow the instructions below:

1. Select **type of Qualified Event** from the table below.
2. Complete section A.
3. Complete section B (if applicable). If you have more dependents or beneficiaries than form space allows, please attach an additional page.
4. Make appropriate selections for Sections C-E.
5. Sign and date page three, and retain a signed copy.
6. Please refer to pg. 4 for required documentation for dependents.
7. Submit the completed, signed, original form and any required supporting documentation to:

**UA Human Resources – Attention Benefits**  
**888 N. Euclid Avenue, Suite 114**  
**P.O. Box 210158**  
**Tucson, Arizona 85721**  
**(520) 621-3662, Option 3    FAX: (520) 621-9098**

*Please identify type of Qualified Life Event Below (Codes are for administrative purposes only.)*

Complete pgs. 1-3 of this document <b>AND</b> provide supporting documentation (pg. 4) for the following:	
<p><b>Gain Significant Other (GSO)</b></p> <p><input type="checkbox"/> *Establishment of <b>Opposite Sex Domestic Partnership</b></p> <p>Date of event: _____</p>	<p><b>Dependent Child Status Change (COE)</b></p> <p><input type="checkbox"/> Dependent reaches age 26</p> <p><input type="checkbox"/> Death of dependent child</p> <p>Date of event: _____</p>
<p><b>Gain Child (GAC)</b></p> <p><input type="checkbox"/> Birth</p> <p><input type="checkbox"/> Adoption</p> <p><input type="checkbox"/> Guardianship</p> <p><input type="checkbox"/> Court Order</p> <p><input type="checkbox"/> Foster Care</p> <p>Date of event: _____</p>	<p><b>Loss or Gain of Benefit Coverage (FSC)</b></p> <p><input type="checkbox"/> Employee loses or gains coverage through:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Medicare/Spouse's/domestic partner's employer                      - If you are being added to or removed from another UA employee's plan, please provide name of that employee: _____</p> <p><input type="checkbox"/> Moves in or out of service area (90 days or longer)</p> <p><input type="checkbox"/> Domestic partner/dependent child(ren) loses/gains coverage (through another plan)</p> <p><input type="checkbox"/> Domestic partner/dependent child(ren) moves in or out of service area</p> <p>Date of event: _____</p>
	<p><b>Leave of Absence</b></p> <p><input type="checkbox"/> Decline Benefits while on Unpaid Leave of Absence (<b>LOA</b>)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Continue Basic Life Insurance (\$1.96/mo)</p> <p><input type="checkbox"/> Reinstate previously waived benefit plans (<b>FSC</b>)</p> <p>Date of event: _____</p>

\*If you are enrolling a **Domestic Partner** you must complete additional required forms. Forms are on the HR website at <http://www.hr.arizona.edu/forms>.

**SECTION A: EMPLOYEE IDENTIFICATION INFORMATION (Print Clearly)**

Last Name, First Name, M.I.		<input type="checkbox"/> Male <input type="checkbox"/> Female	EmplID ( <b>Required</b> ) - - - - -
Work Phone ( )	Cell Phone ( )	Home Phone ( )	Email address:
<b>FOR HR USE ONLY</b>	DATE RECEIVED:	EFFECTIVE DATE:	

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**SECTION B: DEPENDENT INFORMATION** (list dependents being updated and attach supporting documentation)

<b>1</b>	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date __/__/____	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <b>Add</b> <input type="checkbox"/> <b>Delete</b>
	List Address If Different Than Employee's:				
	Relationship	Social Security # __/__/____	Select Plan(s) For This Dependent: <input type="checkbox"/> Fixed Benefit Plan <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
<b>2</b>	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date __/__/____	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <b>Add</b> <input type="checkbox"/> <b>Delete</b>
	List Address If Different Than Employee's:				
	Relationship	Social Security # __/__/____	Select Plan(s) For This Dependent: <input type="checkbox"/> Fixed Benefit Plan <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
<b>3</b>	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date __/__/____	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <b>Add</b> <input type="checkbox"/> <b>Delete</b>
	List Address If Different Than Employee's:				
	Relationship	Social Security # __/__/____	Select Plan(s) For This Dependent: <input type="checkbox"/> Fixed Benefit Plan <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
<b>4</b>	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date __/__/____	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <b>Add</b> <input type="checkbox"/> <b>Delete</b>
	List Address If Different Than Employee's:				
	Relationship	Social Security # __/__/____	Select Plan(s) For This Dependent: <input type="checkbox"/> Fixed Benefit Plan <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
<b>5</b>	Last Name, First Name, M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date __/__/____	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <b>Add</b> <input type="checkbox"/> <b>Delete</b>
	List Address If Different Than Employee's:				
	Relationship	Social Security # __/__/____	Select Plan(s) For This Dependent: <input type="checkbox"/> Fixed Benefit Plan <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		

**SECTION C: SELECT FIXED BENEFIT PLAN**  
(Select- 'Decline', 'No Change', or select a coverage level)

<b>Fixed Benefit Plan-</b> <input type="checkbox"/> No Change <input type="checkbox"/> Decline Coverage			
Provider - Aetna	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee + 1	<input type="checkbox"/> Family

The Fixed Benefit Plan is 100% employer paid and only available during the 90-day waiting period for health benefits.

**SECTION C: SELECT HEALTH BENEFIT PLANS**  
(Select- 'Decline', 'No Change', or select a coverage level and vendor for each plan)

<b>Medical Coverage-</b> <input type="checkbox"/> No Change <input type="checkbox"/> Decline Medical Coverage		
<b>Provider</b>	<b>Employee + Adult</b>	<b>Family</b>
United Health Care	<input type="checkbox"/> \$119.00	<input type="checkbox"/> \$221.00
<b>Dental Coverage-</b> <input type="checkbox"/> No Change <input type="checkbox"/> Decline Dental Coverage		
<b>Provider</b>	<b>Employee + Adult</b>	<b>Family</b>
Delta Dental PPO	<input type="checkbox"/> \$70.88	<input type="checkbox"/> \$123.12
Total Dental ADMIN (contact carrier to select Primary Dental Provider before using services)	<input type="checkbox"/> \$9.00	<input type="checkbox"/> \$14.00
<b>Vision Coverage-</b> <input type="checkbox"/> No Change <input type="checkbox"/> Decline Vision Coverage		
<b>Provider</b>	<b>Employee + Adult</b>	<b>Family</b>
Avesis Vision Coverage	<input type="checkbox"/> \$13.52	<input type="checkbox"/> \$16.86

If you would like to make a change to your Flexible Spending Account Election, please contact the Human Resources office.

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**SECTION D: SHORT-TERM DISABILITY INSURANCE<sup>†</sup> - Note: You may elect only one Short Term Disability plan:**

<b>The Hartford Short Term Disability (STD)</b> (please see the Benefit Guide for Plan Details)			
<input type="checkbox"/> No Change <input type="checkbox"/> Decline The Hartford STD <input type="checkbox"/> Elect The Hartford STD			
<b>Unum Short Term Disability (STD)</b> (please see the Benefit Guide for Plan Details- Options based on maximum salary)			
<input type="checkbox"/> No Change <input type="checkbox"/> Decline Unum STD			
Elect Unum STD (maximum salary) plan <input type="checkbox"/> Option A (\$55,714)      Option B (\$111,430) <input type="checkbox"/> Option C (\$148,571)			
<b>Unum Accidental Death and Dismemberment Beneficiary Information (check and complete applicable fields)</b>			
Name	Birth Date ___/___/_____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date ___/___/_____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date ___/___/_____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

**SECTION E: LIFE INSURANCE<sup>†</sup> (Please elect a beneficiary for Basic Life even if you do not elect Supplemental)**

<b>The Hartford Supplemental Life Insurance (check one)</b>		<b>The Hartford Dependent Life Insurance (check one)</b>	
<input type="checkbox"/> No Change <input type="checkbox"/> Decline		<input type="checkbox"/> No Change <input type="checkbox"/> Decline	
<input type="checkbox"/> *Increase by: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000		Elect a coverage level: <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$6,000	
<input type="checkbox"/> Decrease (increment of \$5,000) \$ _____		<input type="checkbox"/> \$12,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> *\$50,000	
* \$300,000 maximum coverage allowed		*Minimum of \$35,000 Supplemental Life required	
Are You a Non-Smoker? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>The Hartford Beneficiary Information (please select beneficiary for Basic Life \$15,000 even if supplemental insurance is not elected)</b> <input type="checkbox"/> No Change to Hartford Life Insurance Beneficiary designation			
Name	Birth Date ___/___/_____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date ___/___/_____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date ___/___/_____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
<b>Aetna Supplemental Life Insurance (check one- only one step increase per plan year permitted)</b>		<b>Aetna Dependent Life Insurance (check one)</b>	
<input type="checkbox"/> No Change <input type="checkbox"/> Decline		<input type="checkbox"/> No Change <input type="checkbox"/> Decline	
<input type="checkbox"/> Option A (1x Salary) <input type="checkbox"/> Option B (2x Salary)		<input type="checkbox"/> \$5,000 Each Dependent	
<input type="checkbox"/> Option C (3x Salary) (maximum \$300,000)			
<b>Aetna Beneficiary Information</b> <input type="checkbox"/> No Change to Aetna Life Insurance Beneficiary designation			
Name	Birth Date ___/___/_____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date ___/___/_____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Birth Date ___/___/_____	___ % to Pay	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

<sup>†</sup> Plan provisions require that you are actively at work on the effective date of coverage.

**NOTICE TO PROVIDERS**

The contracts between the University of Arizona and its health care plans provide that this document constitutes a valid, temporary membership card and proof of entitlement for all provider services.

**DISCLAIMER**

The information provided on this form is provided solely as a guide to help employees make important enrollment decisions. If there are any discrepancies between this information and official documents, official documents will always govern. The University of Arizona reserves the right to change or terminate any of its plans, in whole or part, at any time.

**DECLARATION FOR BENEFITS**

- I authorize my employer to reduce my salary by applicable pre-tax or post-tax amounts for the benefits I have elected in this form.
- I understand that my medical, dental and vision elections can be changed only during the annual Open Enrollment period, or by writing within 31 days after a qualified life event.
- I am aware that my insurance plan contributions are ineligible as deductions for income tax purposes.
- I authorize the release of this information to my insurance carriers and employer.
- I hereby certify under penalty of perjury that the information I have provided in this form is true and correct. I acknowledge that providing false information may subject me to denial of employment benefits, disciplinary action and potential legal action. I further acknowledge that it is my obligation to keep this information up to date.

By my signature below, I authorize Human Resources to enter form information into the benefits enrollment system, affirm that it is my responsibility to review my confirmation statement and will immediately notify Human Resources of disparities.

**Printed Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**EmpIID:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Email address:** \_\_\_\_\_

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### SECTION F: REQUIRED SUPPORTING DOCUMENTATION

All required documentation must be in or translated to English before submission to Human Resources.

Type of Qualified Life Event	DOCUMENTATION REQUIRED	EFFECTIVE DATE OF COVERAGE
<b>CHANGE IN DEPENDENT CHILDREN</b>		
-Birth	Copy of birth certificate (official or unofficial) or official hospital record	The date of the event
-Adoption -Placement for adoption -Guardianship	Copy of official signed and dated legal document	
-Foster care	Copy of official signed and dated legal document	HR receives the form and coverage begins the first day of the following pay period (please see the payroll calendar for pay period start dates): <a href="http://www.fso.arizona.edu/Payroll/calendars.html">http://www.fso.arizona.edu/Payroll/calendars.html</a>
-Dependent child reaches age 26	Employee signature on this form	The date of the event
Death of dependent child	Copy of death certificate	The day after the date of death
<b>LOSS OR GAIN IN COVERAGE</b>		
-Employee loses/gains coverage through <ul style="list-style-type: none"> <li>• Medicare</li> <li>• Domestic partner's employer</li> </ul> -Domestic partner/dependent child(ren) loses/gains coverage	Copy of enrollment form, ID card, HIPAA certificate or letter from other plan sponsor on letterhead. Information must specify the coverage that is/was effective, including the effective date of loss or gain of coverage and names of all dependents covered (if applicable). If adding to UA plan and spouse or dependent has a different last name, also submit a copy of marriage license or birth certificate	HR receives the form and coverage begins the first day of the following pay period (please see the payroll calendar for pay period start dates): <a href="http://www.fso.arizona.edu/Payroll/calendars.html">http://www.fso.arizona.edu/Payroll/calendars.html</a>
-Employee, domestic partner and dependent moves into service area AND changes permanent residence address OR leaves service area for an anticipated period longer than 90 days AND changes permanent residence address	For change in residence for the employee, the employee must update address in UAccess Self Service – <a href="http://uaccess.arizona.edu/">http://uaccess.arizona.edu/</a>  Contact Human Resources regarding required documentation.	HR receives the form and coverage begins the first day of the following pay period (please see the payroll calendar for pay period start dates): <a href="http://www.fso.arizona.edu/Payroll/calendars.html">http://www.fso.arizona.edu/Payroll/calendars.html</a>