

DECLARATION FOR CHANGE

EMPLOYEE NAME: _____ EIN: _____

EMPLOYEE'S AGENCY: _____

SUBJECT: CHANGE TO BENEFITS

I am submitting the attached State of Arizona Active Employee Enrollment/Change Form, along with all required documentation, to change my benefits due to the following *Qualified Life Event* [check all applicable box(es) and circle all descriptions that apply], which occurred on _____ (date of event).

- Change in legal marital status: (Circle all that apply) Marriage, Death of spouse, Divorce, Annulment, or Legal Separation
- Change in the number of dependents: Birth, Adoption, Placement for adoption, or Death of a dependent
- Change in employment status: Termination or commencement of employment of employee, spouse, or dependent

- Spouse, Dependent or Employee: lost or added coverage under a group plan
- Change in work schedule: Part-time to full-time, full-time to part-time, strike, lockout, commencement of unpaid leave, or return to work from unpaid leave

- Dependent satisfies or ceases to satisfy the requirement.

- Change in place of residence or work site of: Employee, spouse, or dependent (e.g. moving out of/into different county)

Effective dates for QLEs are generally the pay period start date following your agency's receipt of your completed forms. You are responsible for any payroll deductions from the effective date of the change.

I verify that the information provided above is true and correct.

(Employee Signature)

(Date)

Note: This form must be submitted, along with all required benefit election change forms, **within 31 days of the Qualified Life Event.**

Benefit Options
Choice. Value. Health.