ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

DECLARATION FOR CHANGE

PURPOSE: This form is to notify Benefit Options of the Qualified Life Event (QLE) that enables you to change your benefits coverage.

HOW TO USE THIS FORM

- Submit this form, along with the **Active Employee Enrollment Form** and all required documentation **within 31 days of the Qualified Life Event (QLE)**. *Failure to submit required documents will delay the processing of the change*.
- 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.

SECTION A: MEMBER INFORMATION

LAST NAME			FIRST NAME	M.I.
EMPLOYEE ID NUMBER (EIN)	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	❑ FEMALE ❑ MALE	❑ SINGLE ❑ MARRIED
STREET	CITY	ST	ZIP	COUNTY
HOME PHONE	CELL PHONE		EMAIL	

SECTION B: QUALIFYING LIFE EVENT (WITHIN 31 DAYS OF THE EVENT)	DATE OF EVENT
Marital Status	
❑ **Marriage** Required Documentation Examples: Legal marriage certificate, Birth certificate for newly eligible child(ren) **HIPAA SPECIAL ENROLLMENT – ELECT OR DECLINE ANY AND/OR ALL COVERAGES**	
❑ **Divorce/Legal Separation/Annulment** Required Documentation Examples: Divorce decree, Notice of legal separation/legal annulment	
Change in Number of Dependents	
❑ **Birth** Required Documentation Examples: Birth certificate, proof of birth from hospital until certificate received **HIPAA SPECIAL ENROLLMENT – ELECT OR DECLINE ANY AND/OR ALL COVERAGES**	
❑ **Adoption** Required Documentation Example: Legal Adoption Paperwork **HIPAA SPECIAL ENROLLMENT – ELECT OR DECLINE ANY AND/OR ALL COVERAGES**	
❑ **Guardianship** Required Documentation Example: Guardianship Papers	
❑ **Change in Custody** Required Documentation Example: Legal court orders	
❑ **Court Ordered Coverage of Dependents** Required Documentation Example: Legal court orders	
❑ **Death of Dependent and/or Spouse** Required Documentation Example: Death Certificate	
❑ **Removal of Foster Child/Custody/Guardianship** Required Documentation Example: Legal court orders	
Change in Employment Status or Spouse or Dependent's Coverage	
❑ **Gain/Loss of Other Coverage Provided by Spouse** Required Documentation Example: Evidence of previous or new coverage	
❑ **Loss of Children's Health Insurance Program (CHIP) or Medicaid Coverage** Required Documentation Example: Evidence of previous coverage **HIPAA SPECIAL ENROLLMENT – ELECT OR DECLINE ANY AND/OR ALL COVERAGES**	
❑ **Initiation of Leave without Pay Status such as Military Leave** Required Documentation Example: Evidence of change in pay status	
❑ **Return to Work after Approved Leave Without Pay Status (LWOP)** Required Documentation Example: Proof of change	

ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

DECLARATION FOR CHANGE

Change in Residence	
❑ **Change in Place of Residence Effecting Coverage Availability (Dental Only)** Required Documentation Example: Proof of change	
❑ **Change in Country of Residence** Required Documentation Example: Proof of change	
Other Coverage	
❑ **Entitlement/Cancellation of Medicare, Medicaid** Required Documentation Example: Evidence of enrollment or cancellation	
❑ **Qualified Health Plan through the Public Marketplace** Required Documentation Example: Evidence of enrollment or cancellation	
❑ **Change in Spouse's or Dependent's Coverage** Required Documentation Example: Evidence of enrollment or cancellation	
Other	
❑ **Explain Qualifying Event**:	

SECTION C: READ AND INITIAL

I understand that I have only 31 calendar days from the date of my QLE (add newborn, add new spouse due to marriage, divorce, new hire enrollment, etc.) to request a change.	**INITIAL** _____
I understand that if I fail to submit the required documentation and forms within 31 days of my QLE that my QLE **WILL NOT BE PROCESSED** and that I may have to wait until the next open enrollment to make changes.	**INITIAL** _____

SECTION D: EMPLOYEE AUTHORIZATION AND SIGNATURE

I certify under penalty of perjury that the information provided in this application for employee benefits, including Social Security Numbers, addresses, spouse and/or dependent child(ren) information is true and accurate. I understand that providing false information may subject me to a denial of employee benefits, disciplinary action and prosecution pursuant to A.R.S. §13-2310, 13-2311, 13-2407, 13-2702 and other applicable provisions of the law. I acknowledge I have received the Summary of Benefits and Coverage Documents as part of the Affordable Care Act (ACA) electronically via benefitoptions.az.gov. I authorize the release of this information to my employer, the Arizona Department of Administration (ADOA) and insurance carriers. Further:

- I authorize my employer to reduce my salary by pre-tax or after-tax deductions (in accordance with IRS Section 125), either prospectively or retroactively, for my elected benefits. Any pre-tax contributions are ineligible as itemized deductions for income tax purposes.
- I understand that I can only change my benefits during open enrollment or by written notification to ADOA-Benefit Services Division within 30 calendar days of a qualified life event.
- I understand that while on any unpaid status, I am responsible for paying my benefits premiums. Upon return to paid status, I may have pre-tax or after-tax payroll deductions. If I fail to pay premiums as required, my benefits may be cancelled and I will be responsible for any paid claims.

SIGNATURE:_____ **DATE:** _____

RESOURCES | For additional Qualified Life Events information: benefitoptions.az.gov > Employee Tab > Qualified Life Events

QUESTIONS | Contact your agency's benefits resources liaison or contact ADOA - Benefit Services via the information below.

RETURN TO: ARIZONA DEPT. OF ADMINISTRATION-BENEFIT SERVICES DIVISION, 100 N. 15TH AVE, STE 260, PHOENIX, AZ 85007

FAX: 602-542-4744 | BENEFITSISSUES@AZDOA.GOV | PH: 602-542-5008 | TOLL-FREE: 1-800-304-3687 | BENEFITOPTIONS.AZ.GOV