ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

DECLARATION FOR CHANGE
FOR QUALIFIED LIFE EVENT

Note: This form must be submitted, along with the State of Arizona Active Employee Enrollment/Change Form and all required documentation **within 31 days of the Qualified Life Event (QLE)**. 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.

INSURED INFORMATION				
Name: Last	First	MI		Date of Birth
Employee EIN or SSN	Sex ☐M ☐F	Agency		
Street	City	State	Zip	County
Home Phone	Cell Phone	Email		

QUALIFYING LIFE EVENT (WITHIN 31 DAYS FROM THE EVENT)	**Date of Event**
Legal Marital Status	
☐ Marriage Required Documentation Examples: Legal marriage certificate, and birth certificate for newly eligible child(ren)	
☐ 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 receive certificate	
☐ Adoption Required Documentation Example: Legal Adoption paperwork	
☐ Guardianship Required Documentation Example: Guardianship papers	
☐ Custody Change 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	
☐ 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 Required Documentation Example: Proof of change	
☐ Reduction in Hours – 31 days from start of reduction Required Documentation Example: Proof of change	

QUALIFYING LIFE EVENT (WITHIN 31 DAYS FROM THE EVENT) Date of Event	Date of Event
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 Examples: Passport, 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:	
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

Employee Authorization and Signature

I hereby certify, under penalty of perjury, that the information I have provided in this application for employee benefits, including address and spouse and/or dependent information is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. I authorize my employer to reduce my salary by applicable pre-tax dollars or reduce my paycheck by the applicable after-tax dollars for the insurance programs which I have elected. In addition, I have read and understand the declarations. I hereby acknowledge, I have received the Summary of Benefits and Coverage Documents as part of The Affordable Care Act (ACA).

Member Signature: ____ Date: ____________________

Print Name Clearly ____

For additional Qualified Life Events information see http://benefitoptions.az.gov/bsd%20eligibility%202.html