

# 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 <input type="checkbox"/> M <input type="checkbox"/> F		Agency	
Street	City		State	Zip	County
Home Phone		Cell Phone		Email	

QUALIFYING LIFE EVENT (WITHIN 31 DAYS FROM THE EVENT)	Date of Event
<b>Legal Marital Status</b>	
<input type="checkbox"/> <b>Marriage</b> Required Documentation Examples: Legal marriage certificate, and birth certificate for newly eligible child(ren)	
<input type="checkbox"/> <b>Divorce/Legal Separation/Annulment</b> Required Documentation Examples: Divorce decree, Notice of legal separation/legal annulment	
<b>Change in Number of Dependents</b>	
<input type="checkbox"/> <b>Birth</b> Required Documentation Examples: Birth certificate, proof of birth from hospital until receive certificate	
<input type="checkbox"/> <b>Adoption</b> Required Documentation Example: Legal Adoption paperwork	
<input type="checkbox"/> <b>Guardianship</b> Required Documentation Example: Guardianship papers	
<input type="checkbox"/> <b>Custody Change</b> Required Documentation Example: Legal court orders	
<input type="checkbox"/> <b>Court Ordered Coverage of Dependents</b> Required Documentation Example: Legal court orders	
<input type="checkbox"/> <b>Death of Dependent and/or Spouse</b> Required Documentation Example: Death Certificate	
<input type="checkbox"/> <b>Removal of Foster Child/Custody/Guardianship</b> Required Documentation Example: Legal Court Orders	
<b>Change in Employment Status or Spouse or Dependent's Coverage</b>	
<input type="checkbox"/> <b>Gain/Loss of Other Coverage Provided by Spouse</b> Required Documentation Example: Evidence of previous or new coverage	
<input type="checkbox"/> <b>Initiation of Leave without Pay Status such as Military Leave</b> Required Documentation Example: Evidence of change in pay status	
<input type="checkbox"/> <b>Return to Work after Approved Leave without Pay Status</b> Required Documentation Example: Proof of change	
<input type="checkbox"/> <b>Reduction in Hours – 31 days from start of reduction</b> Required Documentation Example: Proof of change	

<b>QUALIFYING LIFE EVENT (WITHIN 31 DAYS FROM THE EVENT) Date of Event</b>	<b>Date of Event</b>
<b>Change in Residence</b>	
<input type="checkbox"/> Change in place of residence effecting coverage availability (Dental Only) Required Documentation Example: Proof of change	
<input type="checkbox"/> Change in country of residence Required Documentation Examples: Passport, proof of change	
<b>Other Coverage</b>	
<input type="checkbox"/> Entitlement/Cancellation of Medicare, Medicaid Required Documentation Example: Evidence of enrollment or cancellation	
<input type="checkbox"/> Qualified Health Plan through the Public Marketplace Required Documentation Example: Evidence of enrollment or cancellation	
<input type="checkbox"/> Change in Spouse's or Dependent's Coverage Required Documentation Example: Evidence of enrollment or cancellation	
<b>Other</b>	
<input type="checkbox"/> Explain Qualifying Event:	
<b>Read and Initial</b>	
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
<b>Employee Authorization and Signature</b>	
<p>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).</p>	
<p>Member Signature: _____ Date: _____</p> <p>Print Name Clearly _____</p>	
<p>For additional Qualified Life Events information see <a href="http://benefitoptions.az.gov/employees/qualified-life-events">benefitoptions.az.gov/employees/qualified-life-events</a></p>	

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

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