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 Date: for changes based on QLEs are generally the pay period start date following your agency's receipt of your completed forms.
- Payroll Deductions: 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
MAILING ADDRESS	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 COVERAGE**	
❑ **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 COVERAGE**	
❑ **ADOPTION** Required Documentation Example: Legal Adoption Paperwork **HIPAA SPECIAL ENROLLMENT – ELECT OR DECLINE ANY AND/OR ALL COVERAGE**	
❑ **GUARDIANSHIP** Required Documentation Example: Guardianship papers	
❑ **CHANGE IN CUSTODY** Required Documentation Example: Legal court order	
❑ **COURT ORDERED COVERAGE OF DEPENDENTS** Required Documentation Example: Legal court order	
❑ **DEATH OF DEPENDENT AND/OR SPOUSE** Required Documentation Example: Death certificate	
❑ **REMOVAL OF FOSTER CHILD/CUSTODY/GUARDIANSHIP** Required Documentation Example: Legal court order	
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 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 (LWOP)** Required Documentation Example: Proof of change	

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SECTION B: Qualifying Life Event - Within 31 Days Of The Event (Continued)	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 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 visit benefitoptions.az.gov > Employee Tab > Qualified Life Events

QUESTIONS | Contact your agency's benefits resources liaison or contact ADOA - Benefit Services Division 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