Request to Change Benefits

PROVIDENCE Health & Services Alaska

Use this form to provide requests to Human Resources regarding a Change in Family Status for health insurance. **All Mid-Year changes must be submitted within 31 days of the allowable event** *[See Summary Plan Description]*, and all necessary documentation must be attached. If you are adding health insurance coverage for yourself or your dependents (including your spouse), it must be due to an ***Involuntary*** loss of other health care coverage, & you may enroll yourself or dependents in this plan prior to the next Open Enrollment period.

_____ _____ _____
Name (Please Print) Employee Badge ID# Phone Number

Add to: ☐ $500 Deductible ☐ $1250 Deductible ☐ Dental

☐ Vision ☐ Life Insurance Amt_____

☐ Dependent Care FSA Amt_____ ☐ Health Care FSA Amt_____

Add Dependents Because:

_____Marriage (attach copy of certificate) _____Birth (attach copy of certificate/proof)

_____Adoption (attach copy of guardianship or adoption)

_____Other [i.e., involuntary loss of other coverage] (attach copy of HIPAA or COBRA notice, etc.)

_____
(Please explain other type of event and provide verification)

Delete from: ☐ Medical ☐ Dental ☐ Vision ☐ Life Insurance ☐ All Benefits

Delete Dependents Because:

_____ Divorce (attach copy of decree)

_____ Other (i.e., gain of other coverage-attach copy of enrollment, change in dependent status, etc.)

_____
(Please explain other type of event and provide verification, if necessary)

Dependent Name	Birth Date	Social Security	Gender	Relationship

I hereby authorize Providence Health System to reduce my salary to cover any required payments for the benefits I have selected. I understand that by signing and submitting this form, I am making elections concerning my benefits. I certify that I have read the plan requirements for a dependent, and that my child qualifies as a tax dependent for my personal tax return for the current year. To the best of my knowledge all information provided to complete the enrollment of this dependent is correct. I understand that if I provide false information, including enrolling ineligible dependents, my claims may not be paid, payments made in error may be recovered, enrollment may be cancelled, there may be a loss of premiums paid, and/or my employment may be terminated.

_____ _____
Employee Signature Date