



**County of Hamilton
2016 Qualifying Event Form**

Date of Qualifying Event:

Qualifying Event Reason:

A. Employee General Information:

First Name: _____ Employee ID: _____
 Last Name: _____ Department #: _____
 Home Phone: (_____) _____ - _____ Email Address: _____
 Street Address: _____
Street address City State Zip Code

B. Benefit Plan Changes

You may elect to edit benefits elections and/or beneficiaries, if those changes are consistent with your Qualifying Event. You can review your current elections in Paycor by logging in and clicking on the Myself Menu and reviewing Benefit Elections. If you wish to edit the current elections and/or beneficiaries, please check the applicable boxes for each plan you wish to edit. You will receive a workflow in Paycor enabling you to make updates to the benefit plans, as checked below.

Medical Dental Vision Basic Life Insurance (beneficiary)
 FSA: Healthcare FSA: Dependent Care Long-Term Disability Spousal Surcharge
 Supplemental Life – Employee Supplemental Life – Spouse Supplemental Life – Child

C. Benefit Enrollee/Dependent Information: *Supporting documentation is required.*

Complete this section if you are **ADDING OR REMOVING** medical, dental, vision or supplemental life insurance for you and/or your dependents.

Employee – Complete only if making changes to employee coverage.	Documentation Included for Employee													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Medical</td> <td style="width: 30%;"><input type="checkbox"/> Adding</td> <td style="width: 30%;"><input type="checkbox"/> Removing</td> </tr> <tr> <td>Dental</td> <td><input type="checkbox"/> Adding</td> <td><input type="checkbox"/> Removing</td> </tr> <tr> <td>Vision</td> <td><input type="checkbox"/> Adding</td> <td><input type="checkbox"/> Removing</td> </tr> <tr> <td>Supplemental Life</td> <td><input type="checkbox"/> Adding</td> <td><input type="checkbox"/> Removing</td> </tr> </table>	Medical	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing	Dental	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing	Vision	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing	Supplemental Life	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing	<input type="checkbox"/> Proof of gain/loss of other coverage.	HR Use Only
Medical	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Dental	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Vision	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Supplemental Life	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												

Spouse – Complete only if making changes to spouse coverage.	Documentation Included for Spouse													
Name: _____ Date of Birth: ____-____-____ Gender: M or F <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Medical*</td> <td style="width: 30%;"><input type="checkbox"/> Adding</td> <td style="width: 30%;"><input type="checkbox"/> Removing</td> </tr> <tr> <td>Dental</td> <td><input type="checkbox"/> Adding</td> <td><input type="checkbox"/> Removing</td> </tr> <tr> <td>Vision</td> <td><input type="checkbox"/> Adding</td> <td><input type="checkbox"/> Removing</td> </tr> <tr> <td>Supplemental Life</td> <td><input type="checkbox"/> Adding</td> <td><input type="checkbox"/> Removing</td> </tr> </table> <p>* You will be assigned the Spousal Surcharge Plan within your collect info process and will be required to select an appropriate response.</p>	Medical*	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing	Dental	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing	Vision	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing	Supplemental Life	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing	<input type="checkbox"/> Copy of marriage license or certificate /divorce decree <input type="checkbox"/> Copy of first page of most recent tax return (The dollar amounts can be marked out). You will not need to provide a tax return if you are newly married in 2016. <input type="checkbox"/> Proof of gain/loss of other coverage.	HR Use Only
Medical*	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Dental	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Vision	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Supplemental Life	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												

Dependent Child 1 – Complete only if making changes to child coverage.	Documentation Included for Dependent Child 2													
Name: _____ Date of Birth: ____-____-____ Gender: M or F Dependent a full-time student? (Supp Life only) Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Copy of birth certificate/adoption paperwork/court order <input type="checkbox"/> (If applicable) Copy of Social Security or physician certification of disability <input type="checkbox"/> Proof of gain/loss of other coverage.	HR Use Only												
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Medical	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Dental	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Vision	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Supplemental Life	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												

Dependent Child 2 – Complete only if making changes to child coverage.	Documentation Included for Dependent Child 3													
Name: _____ Date of Birth: ____-____-____ Gender: M or F Dependent a full-time student? (Supp Life only) Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Copy of birth certificate/adoption paperwork/court order <input type="checkbox"/> (If applicable) Copy of Social Security or physician certification of disability <input type="checkbox"/> Proof of gain/loss of other coverage.	HR Use Only												
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Dental	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Vision	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												
Supplemental Life	<input type="checkbox"/> Adding	<input type="checkbox"/> Removing												

D. Other Benefit Plans to Consider:

OPERS Beneficiary(s):

To view or change your OPERS beneficiary, please login to OPERS at www.opers.org and click on "Member Login" or call 1-800-222-7377.

Deferred Compensation Contributions and Beneficiary(s):

To review or change your Deferred Compensation beneficiary(s), contact the appropriate deferred compensation vendor below:

- CCAO (County Commissioners' Association of Ohio): 1-800-284-0444 ext. 20156
- VOYA Financial: 1-800-451-4702
- Ohio Deferred Compensation: (513) 829-6499 or 1-877-644-6457

Critical Illness and Accident Insurance:

For information on your policy you can contact Humana at 1-877-378-1505

E. Authorization:

I have read and understand all eligibility requirements set forth by Hamilton County. I have been informed of my benefit options and costs. I agree to pay required contributions, if applicable, through payroll deductions. I understand that I may only change my elections if I have a qualifying event and that only changes consistent with that event are allowed. I understand that I must notify my department payroll representative of my qualifying event within 31 days of the event or I may not make any changes. My signature below indicates the information set forth on this form is true and complete to the best of my knowledge. Any false statements on this form shall be considered grounds for discipline, up to and including termination.

Signature: _____

Date: _____

HR USE ONLY:
HRP: _____
Deductions: _____
Scanned: _____