



Pace University
Change in Family Status

Name: _____ UID#: _____

Work Phone Number: _____ E-mail Address: _____

Health Plan – Do not complete this section if you are not making a change to this benefit.

Table with 5 columns: Plan Name, Employee, Employee + 1, Family, No Coverage. Rows include Consumer Core HDHP/HSA Plan, Network Core Plan, Choice Plan, and Vision Plan Only.

Dental Plan – Do not complete this section if you are not making a change to this benefit.

Table with 5 columns: Plan Name, Employee, Employee + 1, Family, No Coverage. Rows include Dental DMO and Dental PPO.

Type of Change in Family Status:

Please attach documentation of your status change along with the change form(s) for your insurance company(ies):

- Birth or adoption
Change in marital status
Dependent no longer eligible for coverage or eligible for new coverage
Employee/Spouse/Domestic Partner change in employment status

I authorize Pace University to make the required deductions from my paychecks based on the above elections. I have been informed of the cost of the coverage based on this election and I understand the corresponding payroll deduction amounts.

In accordance with IRS regulations, I understand that I must submit this election form within 31 days of the date that my family status change occurred. I also understand that the IRS requires that this change be made effective so that there is no gap in benefit coverage and that I will be responsible for any retroactive premiums that are due.

Employee Signature: _____ Date: _____

HR Use Only

Authorized Signature: _____ Date: _____

Date of Event: _____ Effective Date: _____