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.

- Consumer Core HDHP/HSA Plan
- Network Core Plan
- Choice PPO Plan
- CIGNA Vision Plan Only

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

- CIGNA Dental Care (DHMO)
- CIGNA 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: _____________________