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.**

		Employee	Employee + 1	Family	No Coverage
▯	**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.**

		Employee	Employee + 1	Family	No Coverage
▯	**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: ______________________