Roman Catholic Diocese of Owensboro

Qualifying Event Request

Employee Name | **Date Human Resource Notified**

Change in Legal Marital Status	Date of Change	Required Documents
☐ Marriage		Marriage certificate
☐ Divorce/Annulment		Divorce decree/Court ruling for annulment
☐ Legal separation		Court order verifying legal separation
☐ Death of spouse		Death certificate
Change in Number of Dependents	**Date of Change**	**Required Documents**
☐ Birth/Adoption		Birth certificate / Court Order for adoption or placement of adoption
☐ Death		Death certificate
Gain or Loss Eligibility for Other Group Coverage (HIPAA special enrollment)	**Date of Change**	**Required Documents**
☐ Group health plan		Documentation from plan or issuer regarding change in eligibility (with effective date)
Change in Employment Status of Employee or Spouse	**Date of Change**	**Required Documents**
☐ Loss of employment		Termination documents or unemployment application
☐ Start of employment		Employer documentation of employment start date
☐ Leave of absence		Employer documentation stating employee has commenced or returned from leave
Change in Place of Residence	**Date of Change**	**Required Documents**
☐ Change in place of residence of the employee, spouse or dependent that affects plan eligibility		Documents indicating how change in residence affects employee eligibility
Entitlement to Medicare or Medicaid	**Date of Change**	**Required Documents**
☐ Employee, spouse or dependent becomes covered under Medicare or Medicaid or loses eligibility for his or her Medicare or Medicaid coverage (including coverage under a state Children’s Health Insurance Program, or CHIP)		Government verification that coverage was gained or lost
Changes in Coverage	**Date of Change**	**Required Documents**
☐ Significant cost increases		N/A
☐ Significant curtailment of coverage		N/A
☐ Addition or significant improvement of benefits		N/A

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☐	Change in coverage under other employer plan		Documentation from employer showing change in coverage
☐	Loss of health coverage sponsored by governmental or educational institution		Government verification of loss of eligibility
Other		**Date of Change**	**Required Documents**
☐	Change of custody, judgment, court order or decree requiring health coverage		Court documentation, including qualified medical child support order (QMCSO)
☐	COBRA qualifying event		N/A
☐	FMLA leave		N/A
☐	Eligibility for premium assistance subsidy through a Medicaid plan or CHIP		Government verification of eligibility for subsidy (with effective date)
☐	Exchange enrollment		Employee representation regarding enrollment in a plan under an Exchange
☐	Reduction in hours of service to less than 30 hours without loss of eligibility		N/A

Update the following Benefits: ☐ ADD ☐ DROP

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ OTHER ________________________________

Comments

I hereby certify that the information provided above is accurate.

Employee Signature	Date

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