FAMILY STATUS CHANGE FORM

PMB 0141-1
Bureau of Human Resources
Benefits Program
500 East Capitol Ave
Pierre, SD 57501-5070
Phone: 605.773.3148 or 877.573.7347, option 2
Fax: 605.773.6840

SOUTH DAKOTA
state employee
benefits program
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(BHR USE ONLY) Remarks:
_____
_____
_____

PS Initials: _____
Agency : _____ **Emp #** _____

COMPLETE AND RETURN THIS FORM WITHIN 30 DAYS OF THE QUALIFYING CHANGE IN FAMILY STATUS.

Employee Information

_____ _____ _____ _____ **OR** _____
Last Name First Name MI Insurance ID SSN

_____ _____ _____ _____
Address City State Zip

_____/_____/_____ (____)_____ (____)_____ (____)_____
Date of Birth Home Phone Work Phone Cell Phone

_____
Email

Designation of Status Change

"Change in Status" is the Internal Revenue Service rule that allows you to adjust your benefit selections when unforeseen circumstances occur between annual enrollments. Only specific events qualify as a change in family status. (Refer to the list below.) The IRS provides guidelines for family status changes and requires that you maintain legal documentation of the changes in your personal records. Examples of documentation include birth certificate, death certificate, marriage certificate, adoption papers, divorce decree, notice of legal separation, or proof of change in spouse or dependent's employment. Documentation may be required upon request.

Check the event that applies.

- ☐ Birth/Pending Birth or Adoption
- ☐ Marriage
- ☐ Eligible Dependent
- ☐ Beginning Employment
- ☐ Change in Dependent Care
- ☐ Other (explain)_____
- ☐ Death
- ☐ Divorce/Legal Separation
- ☐ Ineligible Dependent
- ☐ Ending Employment
- ☐ Incapacitated/Handicapped Dependent

This change occurred on _____/_____/_____.

Coverage to be Added/Terminated

Emp=Employee Sp=Spouse Ch=Child **Indicate in the table either A=Add or T=Terminate for all plan changes.**

						Flexible Benefits			
	Name	SSN	Date of Birth	Sex	Health	Dental	Vision	Accident Ins.	Hospital Indemnity
EMP									
SP									
CH									
CH									
CH									
CH									

Tobacco Use

Are you a tobacco user? ☐ Yes ☐ No **Is your covered spouse a tobacco user?** ☐ Yes ☐ No

When Adding Coverage

Premiums are paid in advance of the effective date. If you elect coverage to be effective the date of the event, you are authorizing South Dakota State Employee Benefits Program to take a one-time deduction for additional premium(s) (if applicable) from your paycheck. Thereafter, regular semi-monthly or monthly premium will continue to be deducted from your paycheck.

Health coverage should take effect _____/_____/_____.

Flexible benefits (dental, vision, accident insurance, and/or hospital indemnity) should take effect _____/_____/_____.

When Terminating Coverage

Central Payroll Employee (paid semi-monthly):

- Termination date can be the date of the event, the 15th, or end of the month in which the event occurred.

Regent Payroll Employee (paid monthly):

- Termination date can be the date of the event or the end of the month in which the event occurred.

Requested termination date_____/_____/_____.

Spending Accounts

*** Medical Flexible Spending Account: $_____ per pay period for a total of $_____per fiscal year.**
*** Dependent Care/Day Care Spending Account: $_____ per pay period for a total of $_____per fiscal year.**

If adding a Medical Flexible Spending Account or Dependent Care/Day Care Spending Account, it should take effect: _____/_____/_____.

If terminating Medical Flexible Spending Account or Dependent Care/Day Care Spending Account , the requested termination day is: _____/_____/_____.

***** Expenses may be found in the Summary Plan Description at http://benefits.sd.gov/spendingaccounts.aspx or as described under the Internal Revenue Code at www.irs.gov/pub/irs-pdf/p502.pdf.

This is to certify I incurred a family status change(s), and wish to change my plan benefits as indicated on this form. I understand:

- *the change must be consistent with the family status change event and requested within 30 days of the event,*
- *I may be required to provide documentation according to IRS guidelines for the family status change and required to maintain legal documentation of the changes in my personal records. Examples of documentation include: birth certificate, death certificate, marriage certificate, adoption papers, divorce decree, notice of legal separation, or proof of change in spouse or dependent's employment,*
- *if necessary; the South Dakota State Employee Benefits Program may take a one time deduction from a future paycheck for the requested effective date (s), and*
- *the South Dakota State Employee Benefits Program reserves the right to verify family status changes during the plan year. I could face disciplinary action and reduction or loss of my health benefits if I misrepresent family status changes for myself and/or my covered dependents.*

_____ _____

Employee Signature **Date Signed**

An electronic confirmation statement notice will be sent to your email address on file after the Family Status Change form has been processed.