Tufts UNIVERSITY Qualified Status Change Form

Effective Date of Change:

62R Talbot Avenue • Medford, MA 02155 • (617) 627-7000
Fax: (617) 627-7001

You must **submit proper documentation, along with this form**, to Tufts Support Services **within 31 days of your qualified change in status**. The election change will become effective the date Tufts Support Services receives the completed form and all required documentation, except in the case of birth, adoption and placement for adoption, in which case, the effective date is the date of the event.
Please print all information.

Personal Information (Please Print)

Employee Last Name	First Name	MI	University Employee ID Number	Date of Hire
Street Address			Apartment #	Date of Birth
City	State	Zip Code	Home Phone (required)	Work Telephone

Health Plan

☐ **Enroll** ☐ **Change Coverage Level** ☐ **Terminate Coverage** ☐ **No Change**

CURRENT coverage		**NEW coverage**	
Plan Option:	**Covered:**	**Plan Option:**	**Cover:**
☐ Quality Tiered PPO Health Plan	☐ Employee	☐ Quality Tiered PPO Health Plan	☐ Employee
☐ Traditional PPO Health Plan	☐ Employee + One	☐ Traditional PPO Health Plan	☐ Employee + One
☐ Value PPO Health Plan	☐ Family	☐ Value PPO Health Plan	☐ Family
☐ NONE			

Dental Plan Coverage

☐ **Enroll** ☐ **Change Coverage Level** ☐ **Terminate Coverage** ☐ **No Change**

CURRENT coverage		**NEW coverage**	
Plan Option:	**Covered:**	**Plan Option:**	**Cover:**
☐ Delta Premier USA (D)	☐ Employee	☐ Delta Premier USA (D)	☐ Employee
☐ NONE	☐ Employee + One		☐ Employee + One
	☐ Family		☐ Family

Discount Vision Plan

☐ **Enroll** ☐ **Change Coverage Level** ☐ **Terminate Coverage** ☐ **No Change**

CURRENT coverage		**NEW coverage**	
Plan Option:	**Covered:**	**Plan Option:**	**Cover:**
☐ EyeMed Vision Care (V)	☐ Employee	☐ EyeMed Vision Care (V)	☐ Employee
☐ NONE	☐ Employee + One		☐ Employee + One
	☐ Family		☐ Family

Employee, Spouse/Domestic Partner (DP) and Dependent(s) enrollment under the Plan(s):
List all individuals and indicate **ENROLLMENT STATUS for this Qualified Status Change Event** under the health, dental and vision plans, including your legal Spouse/QDP and/or child(ren) under age 26.

You must circle Y (Yes) or N (No) to indicate enrollment status in each plan.

Last, First	Health	Dental	Vision	Birth Date	Gender		Disabled Dependent	Physician's Full Name** *(Optional)*
Employee	Y N	Y N	Y N		F M		-	
Spouse	Y N	Y N	Y N		F M		-	
Domestic Partner*	Y N	Y N	Y N		F M		-	
Dependent	Y N	Y N	Y N		F M		Y N	
Dependent	Y N	Y N	Y N		F M		Y N	

***DP - Domestic Partner is a partnership documented with Tufts University. If enrolling a DP into a Health Plan, an Affidavit of Domestic Partnership must be completed and submitted with this QSCF. Affidavit can be found at: https://access.tufts.edu/forms**

****If enrolling in a Health Plan, all dependent information must be completed. We recommend that a primary care physician be designated, but it is not required. If you do not complete all of the required information, your form cannot be processed.**

Please note: if you have additional dependents, please attach a supplementary sheet indicating Dependent Life Insurance and the above details for each.

University Employee ID Number

Spouse/DP/Dependent Social Security Information

The group health insurance providers require spousal/DP/dependent Social Security information according to the Mandatory Reporting Law (Section 111 of Public Law 110-173).

Spouse/DP/Dependent Name	Social Security Number	Spouse/QDP/Dependent Name	Social Security Number

NOTE: IF YOU HAVE DEPENDENT CHILDREN WHO ARE COVERED ON THE ABOVE PLANS WHO DO NOT RESIDE AT YOUR ADDRESS, PLEASE CONTACT TUFTS SUPPORT SERVICES.

Flexible Spending Accounts (FSAs)

Health Care Flexible Spending Account *(Employee & Eligible Dependents)* ☐ **Enroll (H01)** ☐ **Change Amount** ☐ **No Change**	**Amount of salary reduction $____________/calendar year** (To be divided evenly starting on the date of notification through the end of the current calendar year. Amount cannot exceed $2,600 per year)
Dependent Care Flexible Spending Account *(Child Care Expenses for Dependents under Age 13 or Elder Care expenses)* ☐ **Enroll (D01)** ☐ **Change Amount** ☐ **No Change**	**Amount of salary reduction $____________/calendar year** (To be divided evenly starting on the date of notification through the end of the current calendar year. Amount cannot exceed $5,000 per year)

I understand that any salary reduction amounts credited to my Dependent Care FSA Account will be forfeited if they are not used to cover qualifying expenses incurred during the current plan year. Similarly, any unused balance over $500 in my Health Care FSA will be forfeited. Please see Plan document for further details. Eligible expenses are incurred at the time of service, regardless of when billed or paid. Dependent care expenses must be paid before requesting reimbursement.

LIFE INSURANCE OPTIONS

Per IRS regulations, you may only change your Supplemental Life Insurance policies in the cases of the following:

- Marriage, Divorce, or legal separation,
- Birth, adoption, or placement for adoption of your child

Alternatively, per Massachusetts regulations, you may also change your Supplemental Life Insurance Policies in the case of commencement or termination of a Domestic Partnership.

Life Insurance Beneficiary Designation: You may want to consider updating your Beneficiary Designation online at http://eserve.hr.tufts.edu.

Supplemental Life Insurance

☐ No change To enroll or increase current coverage level see note to right regarding application. Decrease current coverage level to: ☐ 1X salary ☐ 2X salary ☐ 3X salary ☐ 4X salary ☐ Waive Supplemental Life (W)	*Employee contribution required* **Note:** If eligible, you may **enroll in** Supplemental Life coverage by completing a Short Form Health Statement available online at: https://access.tufts.edu/forms Upon completion, the entire form must be submitted directly to Prudential by you, via confidential fax at (617) 587-5998 or via mail to **The Prudential Insurance Company of America, Attention: Melissa O'Brien, 800 Boylston Street, 14th floor, Boston, MA, 02199.** Approvals will be effective on the 1st of the month following the date approved by Prudential.

Dependent Life – Child(ren)

☐ No change ☐ Enroll/change existing coverage (complete information below) ☐ Waive Dependent Life Child(ren) Coverage (W)	*Employee contribution required* ☐ $10,000 (DC1)

Child(ren) Full Name	Relationship	Gender	Date of Birth

***Please note: if you have additional dependents, please attach a supplementary sheet indicating Dependent Life Insurance and the above details for each.**

University Employee ID Number

Dependent Life – Spouse/DP

☐ No change *To enroll or increase current coverage level, see note to right regarding application.* ☐ Decrease current coverage level to $25,000 ☐ Waive Dependent Life Spouse/QDP Coverage (W) Note: Your Spouse's/Domestic Partner's insurance amount cannot exceed 100% of your combined basic and supplemental life insurance coverage amount. See note to right regarding application.	*Employee contribution required.* **Note:** If eligible, you may **enroll in** Dependent Life coverage by completing a Short Form Health Statement available online at: https://access.tufts.edu/forms Upon completion, the entire form must be submitted directly to Prudential by you, via confidential fax at (617) 587-5998 or via mail to **The Prudential Insurance Company of America, Attention: Melissa O'Brien, 800 Boylston Street, 14th floor, Boston, MA, 02199.** All approvals will be effective on the 1st of the month following the date approved by Prudential.

Spouse/DP Full Name	Relationship	Gender	Date of Birth

Qualified Event

I understand the above and confirm that I experienced this status change on ____________________(event date). The election change will become effective as noted in the table below. **Please check the appropriate box to verify that you have had a qualified change in status:**

QUALIFIED EVENT	REQUIRED DOCUMENTATION OF PROOF & EFFECTIVE DATE
☐ Marriage, or commencement of Domestic Partnership;	Marriage Certificate or Statement of Domestic Partnership **Election changes effective on: the date of the event or date this form and documentation is received by the HR Benefits Office, whichever is later.**
☐ Divorce, legal separation, or termination of a Domestic Partnership;	Court Document or Statement of Termination of Domestic Partnership **Election changes effective on: date this form and documentation is received by the HR Benefits Office unless the legal document stipulates otherwise.**
☐ Birth, adoption or placement for adoption of your child;	Birth Certificate or Statement of Birth Record for newborn child or completed Adoption Paperwork **Election changes effective on: the date of the event.**
☐ Death of a Spouse/DP or dependent;	Death Certificate **Election changes effective on: the date of the event or date this form and documentation is received by the HR Benefits Office, whichever is later.**
☐ You, your Spouse/DP or eligible dependent incurs a loss of employer-sponsored plan coverage;	Employer documentation is needed **Election changes effective on: the date of the event or date this form and documentation is received by the HR Benefits Office, whichever is later.**
☐ A move out of your health plan's service area;	Change of address form must be completed **Election changes effective on: the date of the event or date this form and documentation is received by the HR Benefits Office, whichever is later.**
☐ You, your Spouse/DP or eligible dependent begins or returns from an unpaid leave of absence;	Employer documentation is needed **Election changes effective on: the date of the event or date this form and documentation is received by the HR Benefits Office, whichever is later.**
☐ You, your Spouse/DP or eligible dependent has a change in job status that effects eligibility for coverage under a Tufts University benefit plan or a plan of your eligible dependent's employer;	Employer documentation is needed **Election changes effective on: the date of the event or date this form and documentation is received by the HR Benefits Office, whichever is later.**
☐ You, your Spouse/DP or eligible dependent has a change in status that affects eligibility for coverage under Medicare, Medicaid, or Mass Health;	Documentation is needed from Social Security or Department of Health **Election changes effective on: the date of the event or date this form and documentation is received by the HR Benefits Office, whichever is later.**
☐ You or your eligible dependent reached age 26.	Employer documentation is needed **Election changes effective on: the date of the event or date this form and documentation is received by the HR Benefits Office, whichever is later.**
☐ Other. Please explain:	

University Employee ID Number

PLEASE NOTE: When adding your Spouse/DP and eligible dependents to your insurance policies due to a change in their existing insurance coverage, we require documentation that includes the following:

1. What type of plan is involved (health, dental, vision, etc.)
2. The full names of all individuals covered under the plan
3. The date coverage ended or will end
4. Reason for change

PLEASE NOTE: When terminating your Spouse/DP and eligible dependents from your insurance policies due to a new insurance policy, or when terminating your own Tufts University insurance coverage, we require documentation that includes the following:

1. What type of plan is involved (health, dental, vision, etc.)
2. The full names of all individuals covered under the plan
3. The date coverage began or will begin

YOUR BENEFIT CHANGES WILL **NOT BE PROCESSED** WITHOUT THIS INFORMATION PER IRS REGULATIONS.

Salary Reduction Agreement

- My salary will be reduced by any amounts to be credited to my Health or Dependent Care Flexible Spending Account and by the same amount as my required contribution from time to time for the health, dental and vision options (except the portion deducted to cover a Domestic Partner [“DP”]) that I have elected.
- After the effective date of this agreement, I will not be permitted to change my benefit elections until the new plan year, and if I do not make a new election at that time, I will be treated as having elected to continue the health, dental and vision coverages then in effect for a new plan year and having agreed to the continuation of the above salary reduction agreement in the amount of the required contributions for these coverages.
- If I do not make a new election with respect to Health or Dependent Care Flexible Spending Accounts, the coverage then in effect will cease at the end of the plan year.
- I may change my election only if I have a qualified change in status, in accordance with IRS regulations.
- This agreement will terminate as to any benefit coverage if I cease to be eligible for that coverage or if that coverage or this plan terminates. The reduction(s) in my salary under this agreement shall be in addition to, and not in lieu of, any reduction(s) under other agreements or benefit plans.
- Any previous election and salary reduction agreement under this plan is hereby revoked.
- My salary reduction will automatically stop if I cease to receive sufficient salary.
- If I leave the University or become ineligible for benefits, and then regain eligibility, or am rehired during the same plan year and have unpaid contributions for prior benefits coverage, I authorize Tufts University to deduct those unpaid amounts from my wages.
- My salary reduction amount may have an impact on my Social Security benefits at retirement and Tufts University cannot guarantee the tax treatment of my FSA contribution.
- I assign benefits to the health plan providers, which means that when I (we) receive covered services from the health plan providers, the health plan is authorized to make payments directly to those providers for services rendered to me (us). I grant the plan or the insurer underwriting the health plan benefits, whichever applies, any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid for by this coverage. I agree that the health plan and health care providers (and in the case of self-funded employers, my employer) may obtain or release my (our) health records and health service-related information for the following purposes: (a) administering benefits; (b) managing care, including utilization review, quality assurance and member satisfaction procedures(c) conducting bona fide health research and (d) when required by law. I understand that the benefits for which I (we) will be eligible are those described in the applicable insurance Certificate, Summary Plan Description, or Description of Benefits.
- I understand the group health plans and the university will not use or further disclose my protected health information except as necessary for treatment, payment, health plan operations, and plan administration, or as otherwise permitted or required by applicable law. Some uses and disclosures may be made without my consent, including disclosures to government agencies for health oversight activities, workers’ compensation, and law enforcement. Other disclosures may be made only with my written authorization, such as marketing communications that encourage me to purchase or use a specific product or service. When using or disclosing protected health information, the group health plans will strive to limit the protected health information to the minimum necessary to accomplish the intended use, disclosure, or request.
- Additionally, I understand the university has also implemented safeguards to protect the confidentiality, integrity and availability of electronic protected health information, implemented security measures to ensure adequate separation between the University and the benefit plans, and ensure that any agent to whom it provides electronic protected health information also agrees to implement reasonable and appropriate security measures. The University will report to the group health plans any security incident of which it becomes aware involving electronic protected health information.
- I understand that the benefits for which I (we) will be eligible are those described in the applicable insurance Certificate, Summary Plan Description, or Description of Benefits.
- The information that I have provided with respect to benefits eligibility for me and any dependents I enroll is accurate and true to the best of my knowledge.

Print Employee Name	Employee Signature	Date	HR Benefits Office Signature	Date