Qualifying Event Form

Aurora Public Schools
Every student shapes a successful future.

EMPLOYEE NAME WORK SITE APS ID # DATE

You can make changes to your benefits during the year based on certain life events such as changes in your family including employment status changes or loss or addition of coverage elsewhere. In all cases, the change in coverage you request must be consistent with the life change.

In accordance with IRS guidelines, you have 30 days from the event to make changes to your elections by submitting this completed form and the indicated documentation to the APS Benefits office. If you do not notify Benefits within 30 days of the change, you will not be able to modify your coverage levels until the next open enrollment period.*

Date of Event	Qualifying Event	Documentation Required	Effective Date of Coverage Change
	Change in marital status ☐ Marriage ☐ Legal separation ☐ Divorce	• Copy of marriage license or certificate • Copy of separation or annulment paperwork • Copy of divorce decree	First of the month following event or following notification, whichever date is later.
	Birth/Adoption/Custody of a child	• Copy of birth certificate or hospital certificate • Copy of adoption or custody verification documentation	Date of birth/adoption/custody
	Loss of coverage Explanation:	• Documentation verifying date coverage ended	First of the month following event or following notification, whichever date is later.
	Acquired new coverage elsewhere Explanation:	• Documentation verifying date new coverage began	First of the month following event or following notification, whichever date is later.
	Change in dependent care provider	• Documentation showing the change in provider	First pay period following the change.
	Going out or returning from an approved leave of absence		

*For loss or gain of Medicare, Medicaid, or CHP+ coverage you have 60 days to notify APS.

Rates and plan information can be found at hr.aurorak12.org
Questions? Contact benefitshr@aps.k12.co.us

	Name (Fill in names of anyone who is currently enrolled on your insurance and who you are adding, if applicable)	SSN	Sex (M/F)	Date of Birth (MM/DD/YY)	Current Coverage			New Coverage		
					Medical	Dental	Vision	Medical	Dental	Vision
Self					☐	☐	☐	☐	☐	☐
Spouse/ Partner					☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐
Child					☐	☐	☐	☐	☐	☐

DEPENDENT STATUS- REQUIRED

Medical, dental and/or vision coverage is available for an APS employee's common law spouse. An affidavit of common law marriage is required to enroll a common law spouse in a medical, dental and/or vision plan.

Medical, dental and/or vision coverage is also available to an APS employee's domestic partner or partner in a civil union, and such partner's dependent children. An affidavit certifying the existence of the domestic partnership or a civil union license is required to enroll a domestic partner or partner in a civil union (or such partner's dependent children) in a medical, dental and/or vision plan.

Pursuant to IRS regulations, if an APS employee's domestic partner or partner in a civil union, or such partner's dependent children, are enrolled in a medical, dental and/or vision plan:

> The employee's portion of the premium will be deducted pre-tax (unless after-tax is elected), and the portion of the premium attributable to the domestic partner, partner in a civil union, and/or the partner's dependent children will be deducted after-tax, unless the covered individual is the APS employee's dependent as described in Internal Revenue Code Section 105(b).

Select at least one of the options below:

☐ I will be covering a domestic partner/ partner in a civil union

☐ I will be covering a common law spouse

☐ I will be covering the child(ren) of a domestic partner/ partner in a civil union

☐ None of the above

MEDICAL COVERAGE ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

- If yes, choose your plan (choose one):
  - ☐ Kaiser DHMO $1000 ☐ Kaiser HDHP $1500 ☐ Kaiser POS $1000
  - ☐ Kaiser DHMO $2500 ☐ Kaiser HDHP $3000

DENTAL COVERAGE ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

- If yes, choose your plan (choose one):
  - ☐ Delta Dental Base Plan
  - ☐ Delta Dental Buy-up Plan

VISION COVERAGE ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

☐ EyeMed Vision Plan

FLEXIBLE HEALTHCARE SPENDING ACCOUNT ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

☐ I would like to enroll/ change my FSA monthly contribution to $________ ($2650 annual limit)

☐ No change

HEALTH SAVINGS ACCOUNT (HSA) ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

☐ I would like to enroll/ change my monthly contribution to $________ ($3450 individual or $6900 family annual limit for 2018 tax year)

☐ No change

DEPENDENT CARE SPENDING ACCOUNT ☐ YES OR ☐ NO (SKIP TO NEXT SECTION)

☐ I would like to enroll/ change my monthly contribution to $________ ($5000 annual limit)

☐ No change

SIGNATURE

By signing below, I commit to the accuracy of this information. I understand falsifying this form can result in loss of coverage, additional premiums, and further disciplinary action up to and including termination.

I authorize the elections I have made and the payments required for those elections. I understand that any payroll deductions will be made from my paycheck. I also understand that the elections cannot be changed unless I have a qualifying event.

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SIGNATURE DATE

Please return this enrollment form to APS Benefits by interoffice mail, fax to 303-326-1922, email to benefitshr@aps.k12.co.us, or drop off at 1085 Peoria St. within 30 days of your qualifying event.