DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Qualified Life Event Form

CHECKLIST FOR COMPLETING A QUALIFIED LIFE EVENT FORM

All Life Events must be reported within 31 days of your Life Event Effective Date

To help us process your Qualifying Life Event, please complete the following:

- ☐ Employee Name
- ☐ University ID
- ☐ Qualified Life Event Effective Date
- ☐ Daytime Phone Number
- ☐ Life Event Reason (indicate only ***one*** reason)
- ☐ Required Documentation Information (***must complete for all eligible dependents***)
- ☐ Medical Election
- ☐ Dental Election
- ☐ Vision Election
- ☐ Employee Supplemental Life Insurance Election
- ☐ Spouse Life Insurance Election
- ☐ Child Life Insurance Election
- ☐ AD&D Insurance
- ☐ Health Care Spending Account Election
- ☐ Dependent Care Spending Account Election
- ☐ Employee Signature and Date
- ☐ Attach Valid Supporting Documentation to the Major Life Event Form

If any of the items above are not completed or included, your Qualified Life Event Form will not be processed and your change in elections will be delayed. Please refer to page two for examples of valid Life Event supporting documentation.

If you have any questions or concerns, please contact the Benefits Service Center: 1.866.806.0949 (Drexel University) or 1.866.806.0950 (DUCOM).

EXAMPLES OF VALID SUPPORTING DOCUMENTATION

Life Event	Example
Marriage	Copy of Marriage Certificate
Divorce	Court Documents (must include the effective date of the divorce)
Birth/Adoption/Legal Custody of Child	Birth Certificate, Hospital discharge paperwork (must provide newborn's name and date of birth), or Court Documents (must include the effective date of the custody of child)
Death of Dependent	Copy of Death Certificate
Gain of Spouse Employment	Letter from employer or carrier(s) listing the dependent's name, the type of coverage(s) gained and the effective date of coverage(s)
Loss of Spouse Employment	HIPAA Certificate, or letter from employer or carrier(s) listing the dependent's name, the type of coverage(s) lost and the effective date of the terminated coverage)
Child(ren) Gain Legal Dependent Status	Court Documents (must include the effective date of the status change), verification from the accredited college/institution indicating full-time student status or a tuition statement indicating the number of course credits per semester
Child(ren) Cease Legal Dependent Status	Court Documents (must include the effective date of the status change), or verification from the accredited college/institution indicating the last date as a full-time student (i.e. Graduation)
Open Enrollment Under Plan of Other Employer	Letter from employer or carrier(s) listing the change in coverage and the effective date
Change of Employment Status Eligibility	No employee action required for supporting documents
Move Out of Service Area (Includes employees and dependents)	No employee action required for supporting documents
Employee's Commencement of Family Medical Leave of Absence	No employee action required for supporting documents
Loss of Employee's Eligibility	No employee action required for supporting documents
Employee's Return from Family Medical Leave of Absence	No employee action required for supporting documents

All changes to benefits are effective the 1st of the month following the date of the event, unless the date of the event falls on the 1st of the month. In that case the benefits are effective that day. Newborns' benefits are effective as of the date of birth.

All correspondance from employers, carriers, and/or colleges/institutions must be provided on respective letterhead.

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Qualified Life Event Form

This form must be completed when you have a Qualifying Life Event as defined in the Drexel University Benefit Booklet.

If you have a Qualifying Life Event that affects **ANY** of your Drexel University benefits, it is ***your responsibility*** to complete this form and send it to the address below within 31 days of the qualifying event. Otherwise, you will NOT be able to change your benefits until the next annual enrollment period. This form allows you to change the Coverage Level Only. This form does NOT allow you or a family member to change from one plan to another. You are responsible for follow-up to ensure that your status change has been received and processed. This form must be accompanied by appropriate documentation (i.e. marriage/death/birth or hospital certificate, etc.), which reflect the effective date of the qualifying event. Payroll increases/decreases will be reflected when approved. It is your responsibility to complete and forward the proper paperwork in a timely manner. ***No refunds will be given***. This document may be copied if multiple forms are necessary.

Please keep a copy of the complete forms for your files.

Employee Name _____ University ID _____

Qualifying Event _____ Daytime Telephone _____

Event Date _____ Effective Date _____

ADDITIONS/DOCUMENTATION NEEDED

- ☐ Adoption: Placement of Papers of Adoption
- ☐ Birth: Certificate of Birth or Hospital Certificate
- ☐ Death of Spouse: Death Certificate
- ☐ Dependent Now Eligible: Copy of School Registration
- ☐ Divorce: Divorce Decree
- ☐ Legal Guardianship: Copy of Court Order
- ☐ Legal Separation: Attorney Letter
- ☐ Marriage: Marriage Certificate
- ☐ Open Enrollment Under Spouse's Plan: Employer Letter
- ☐ Spouse's Employment Terms: Employer Letter or Carrier Statement
- ☐ Expiration of COBRA coverage: Expiration Letter

DELETIONS/DOCUMENTATION NEEDED

- ☐ Death of Spouse: Death Certificate
- ☐ Death of Child: Death Certificate
- ☐ Dependent Now Ineligible: Letter from Employee
- ☐ Divorce: Divorce Decree
- ☐ Employment of Spouse: Proof of Coverage
- ☐ Marriage: Marriage Certificate
- ☐ Medicare Entitlement: Medicare Letter

REQUIRED DEPENDENT INFORMATION

Name (Last, First)	SSN	Date of Birth	Gender	Relation (S=Spouse, C=Child, H=Handicapped)	Medical	Dental	Vision	Life
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

MEDICAL

Plan: ☐ Personal Choice Basic PPO ☐ Personal Choice High PPO ☐ Keystone POS

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

***If waiving Medical coverage, the waiver information at the end of the form MUST be filled out and returned with the change form. Failure to do so will delay processing.**

DENTAL

Plan: ☐ Met Life Basic PPO ☐ Met Life Preferred PPO

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

VISION

Plan: ☐ EyeMed

Coverage Level: ☐ Waive ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

SUPPLEMENTAL LIFE INSURANCE

Employee: ☐ Waive ☐ 1x Base Salary* ☐ 2x Base Salary* ☐ 3x Base Salary* ☐ 4x Base Salary*

Spouse: ☐ Waive ☐ _____ in increments of $10,000, up to $150,000.00

Child: ☐ Waive ☐ $5,000 ☐ $10,000

*Most increases require and Evidence of Insurability form to be completed and returned to Trion

SUPPLEMENTAL AD&D INSURANCE

Employee: ☐ Waive ☐ 1x Base Salary ☐ 2x Base Salary ☐ 3x Base Salary ☐ 4x Base Salary

Spouse: ☐ Waive ☐ $25,000 ☐ $50,000 ☐ $100,000

Child: ☐ Waive ☐ $10,000

FLEXIBLE SPENDING ACCOUNTS

Health Care Spending Account:		Cost per Pay	Total for Year	
Dependent Care Spending Account:		Cost per Pay	Total for Year	
Mass Transit Account:		Cost per Pay	Total for Year	
Parking Account:		Cost per Pay	Total for Year	

Employee Name _____ University ID _____

Employee Signature _____ Date _____

Please complete and return this form, along with appropriate documentation, to 800.291.9629(fax) or mail to:

Drexel Benefits Service Center
2300 Renaissance Boulevard
King of Prussia, PA 19406

DREXEL UNIVERSITY
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Medical Waiver (Opt-Out) Statement
January 1, 2010 to December 31, 2010 Plan Year

This form must be completed if you are waiving Medical Coverage under the Drexel University Benefits Plan for the first time and want to receive the Monthly Opt-Out Bonus. If you have previously completed this form you do not need to fill this out again, the copy we have on file is sufficient.

***Please Note**: Federal regulations prohibit Medicare eligible employees over age 65 who waive their employer's medical coverage from receiving a waiver bonus if their primary source of other coverage is Medicare.*

Employee Name _____ University ID _____

I am covered under the following Insurance program(s) _____

Employee under whom you are covered _____

Employer sponsoring the plan _____

Medical Insurance Carrier _____

Policy Numbers _____

Additional proof of this coverage is required. Please attach a copy of your medical ID card to this form in order to Waive (Opt-Out) your Medical coverage.

Important Notice: To receive your Waiver Bonus, The Benefit Service Center must have a completed form on file. If you have not previously completed this form, please do so and return it to the Benefit Service Center at the address listed below immediately following your enrollment. Failure to return this form will result in your enrollment in the Default Plan with appropriate per pay deductions and the forfeiture of the Waiver Bonus.

I understand that by opting out as a primary participant, neither I, nor any of my eligible dependents are covered under the Drexel University Medical Insurance Plan. However, if my spouse also works for Drexel University, I will be able to receive coverage as a dependent of him/her. I also understand that unless I experience a Qualified Life Event, **(marriage reconciliation of legal separation, birth or legal adoption of child, change in legal custody of dependents, child is no longer eligible for coverage, child age 19 through 22 becomes full-time student, death of a spouse or child, spouse gains employment or becomes eligible for benefits through employer, spouse's employment terminates or he or she is no longer eligible for benefits through employer, employee on severance becomes employed or becomes eligible for benefits through new employer, a QMCSO requires you to provide for medical coverage for your child(ren) or relieves you from the responsibility of providing medical coverage for your child(ren), you or your spouse becomes eligible for Medicare and elect Medicare as the sole medical coverage, Leave of Absence)**, I will be unable to elect coverage until the next Open Enrollment.

Employee Signature _____ Date _____

Please return completed form to 800.291.9629 (fax), or mail to:
Drexel Benefits Service Center
2300 Renaissance Blvd
King of Prussia, PA 19406