QUALIFYING LIFE EVENT/DEPENDENT VERIFICATION FORM

TO: HUMAN RESOURCES	**(Change must be completed with 30 days of event)**
FAX 828-262-6489 or EMAIL: CLARKSN@APPSTATE.EDU HAMBYKA@APPSTATE.EDU	
SECTION A: EMPLOYEE INFORMATION	
Name: Last, First, MI):	**Date of Birth:**
Banner ID or last 4 of SSN:	**Contact Phone#:**
Employee Email Address:	

SECTION B: TYPE OF QUALIFYING LIFE EVENT – Check only one & indicate Date of Event

Type of Life Event Change (Must be done within 30 days)	Required Documentation to be maintained at Agency level	Date of Event
⌋ New Born	Birth Certificate	
⌋ Acquired Guardianship (adoption/foster child)	Legal Guardianship document from the Courts	
⌋ Marriage	Marriage Certificate	
⌋ Divorce	Divorce Decree	
⌋ Legal Separation	Legal Separation document from the Courts	
⌋ Death	Death Certificate	
⌋ Gain of Dependent's Benefits	Certificate of Coverage showing Effective Date	
⌋ Loss of Dependent's Benefits	Certificate of Coverage showing Term Date*	
⌋ Medicare Eligibility	Certificate of Coverage showing Medicare Effective	
⌋ Gain of Other Coverage	Certificate of Coverage showing Effective Date	
⌋ Loss of Other Coverage	Certificate of Coverage showing Term Date*	
⌋ Change in Medicaid	Medicaid Letter showing Change Date*	
⌋ Court Order	Court Order document	

***May also require Dependent Verification Documentation (i.e., birth certificate, marriage certificate, etc.)Can be provided within 30 days of changing coverage.**

SECTION C: Dependent Information – Please indicate dependent's name, DOB & relationship to employee

Dependent Name:	Date of Birth	Social Security #	Relationship:	Doctors Name