

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
<input type="checkbox"/> New Born	Birth Certificate	
<input type="checkbox"/> Acquired Guardianship (adoption/foster child)	Legal Guardianship document from the Courts	
<input type="checkbox"/> Marriage	Marriage Certificate	
<input type="checkbox"/> Divorce	Divorce Decree	
<input type="checkbox"/> Legal Separation	Legal Separation document from the Courts	
<input type="checkbox"/> Death	Death Certificate	
<input type="checkbox"/> Gain of Dependent’s Benefits	Certificate of Coverage showing Effective Date	
<input type="checkbox"/> Loss of Dependent’s Benefits	Certificate of Coverage showing Term Date*	
<input type="checkbox"/> Medicare Eligibility	Certificate of Coverage showing Medicare Effective	
<input type="checkbox"/> Gain of Other Coverage	Certificate of Coverage showing Effective Date	
<input type="checkbox"/> Loss of Other Coverage	Certificate of Coverage showing Term Date*	
<input type="checkbox"/> Change in Medicaid	Medicaid Letter showing Change Date*	
<input type="checkbox"/> 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