

Tufts University Qualified Status Change



Benefits Election Form And Salary Reduction Agreement

When participating in a Tufts University Health, Dental, Vision Plan or Flexible Spending Account, your premiums are deducted on a “pre-tax” basis (before Federal, State, and FICA taxes are deducted). The Internal Revenue Service (IRS) allows employers to shelter these premiums, but stipulates that employees cannot change their enrollment “choice” (i.e. change their enrollment status or coverage level) except during the Annual Open Enrollment period, due to a Qualified Change in Status or other permissible events under the Tufts University cafeteria plan. The Annual Open Enrollment period runs within the month of November each year, with an effective date of January 1 of the following year.

You must submit proper documentation, along with this form, which must be signed and submitted to the Human Resources Benefits Office within 31 days of your Qualified Change in Status. Your benefits become effective on the date of the event, unless otherwise noted. If you have any questions on how to complete this form, please contact the Human Resources Benefits Office at 617-627-3270.



200 Boston Avenue • Suite 1600 • Medford, MA 02155 • (617) 627-3270
 Fax: (617) 627-3615

Semi-Monthly
 Weekly
 Effective Date of Change: _____

You must submit proper documentation, along with this form, to the Human Resources Benefits Office **within 31 days of your qualified change in status**. The election change will become effective the date the Human Resources Benefits Office receives the completed form, except in the case of marriage, birth, adoption, and placement for adoption, in which case of the effective date is the date of the event.

Please print all information and press firmly.

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	Work Telephone

Health Plan

<input type="checkbox"/> Enroll	<input type="checkbox"/> Change Coverage Level	<input type="checkbox"/> Terminate Coverage (W)*	<input type="checkbox"/> No Change
<input type="checkbox"/> Fallon Community Health Plan (F) <input type="checkbox"/> Harvard Pilgrim Health Care (H) <input type="checkbox"/> Tufts Health Plan POS (T) <input type="checkbox"/> Tufts Health Plan EPO (P)		<input type="checkbox"/> Employee <input type="checkbox"/> Employee + One <input type="checkbox"/> Family	
HR Benefits Office Use Only Previous Coverage _____		HR Benefits Office Use Only Benefit Code _____	
<i>*Please Note: If you terminate health coverage, you are required to complete a Commonwealth of Massachusetts HIRD (Health Insurance Responsibility Disclosure) and return it to the HR Benefits Office, along with this form.</i>			

Dental Plan

<input type="checkbox"/> Enroll	<input type="checkbox"/> Change Coverage Level	<input type="checkbox"/> Terminate Coverage (W)	<input type="checkbox"/> No Change
<input type="checkbox"/> Delta Premier USA (D)		<input type="checkbox"/> Employee <input type="checkbox"/> Employee + One <input type="checkbox"/> Family	
HR Benefits Office Use Only Previous Coverage _____		HR Benefits Office Use Only Benefit Code _____	

Discount Vision Plan

<input type="checkbox"/> Enroll	<input type="checkbox"/> Change Coverage Level	<input type="checkbox"/> Terminate Coverage (W)	<input type="checkbox"/> No Change
<input type="checkbox"/> EyeMed Vision Care (V)		<input type="checkbox"/> Employee <input type="checkbox"/> Employee + One <input type="checkbox"/> Family	
HR Benefits Office Use Only Previous Coverage _____		HR Benefits Office Use Only Benefit Code _____	

Employee, Spouse/Partner and Dependent(s) to be covered under the Plan(s).

List all individuals to be **COVERED** under the health, dental, or vision plans, including your legal spouse; qualified same-sex domestic partner; child(ren) under age 19; children age 19 to 26 who do not have coverage as an employee or dependent under his/her spouse's employer sponsored plan. (Affidavit confirming eligibility for child(ren) age 19-26 will be required.) **Please circle Y or N to indicate enrollment in each plan.**

Last, First, MI	Health	Dental	Vision	Birth Date	Gender	Dependent Age 19-26	Disabled Dependent	Physician's Full Name** Last, First
Employee	Y N	Y N	Y N		F M	-	-	
Spouse/QDP*	Y N	Y N	Y N		F M	-	-	
Dependent	Y N	Y N	Y N		F M	Y N	Y N	
Dependent	Y N	Y N	Y N		F M	Y N	Y N	
Dependent	Y N	Y N	Y N		F M	Y N	Y N	
Dependent	Y N	Y N	Y N		F M	Y N	Y N	

*QDP-Qualified Domestic Partner is a same-sex partner in a partnership documented with Tufts University.

** If enrolling in a Health Plan, all dependent information must be completed and a primary care physician must be selected. If you do not complete all of the required information, your form will not be processed.

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University Employee ID Number

Spouse/QDP/Dependent Social Security Information

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

Spouse/QDP/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 THE HR BENEFITS OFFICE.

Flexible Spending Accounts

Health Care Flexible Spending Account (Employee & Eligible Dependents) <input type="checkbox"/> Enroll (H01) <input type="checkbox"/> Change Amount <input type="checkbox"/> No Change	Amount of salary reduction \$ _____/calendar year (To be divided evenly throughout the remainder of the calendar year. Not to exceed \$5,000 per year)
Dependent Care Flexible Spending Account (Child Care Expenses for Dependents Age 13 & Under) <input type="checkbox"/> Enroll (H01) <input type="checkbox"/> Change Amount <input type="checkbox"/> No Change	Amount of salary reduction \$ _____/calendar year (To be divided evenly throughout the remainder of the calendar year. Not to exceed \$5,000 per year)
I understand that any salary reduction amounts credited to my Account will be forfeited if they are not used to cover qualifying expenses incurred during the current plan year. Expenses are incurred at the time the services to which the expenses relate are rendered and not when they are billed or paid for.	

LIFE INSURANCE OPTIONS

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

- Marriage or the commencement of a Qualified Same-Sex Domestic Partnership
- Divorce, legal separation, or termination of a Qualified Same-Sex Domestic Partnership
- Birth, adoption, or placement for adoption of your child

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

Supplemental Life Insurance

<input type="checkbox"/> No change <input type="checkbox"/> Enroll: <input type="checkbox"/> 1X salary, <input type="checkbox"/> 2X salary, or <input type="checkbox"/> 3X salary <input type="checkbox"/> Decrease current coverage level to: <input type="checkbox"/> 1X salary, <input type="checkbox"/> 2X salary, or <input type="checkbox"/> 3X salary <input type="checkbox"/> Waive Supplemental Life (W)	Employee contribution required To enroll in 4X or 5X coverage, or if your combined coverage is over \$750,000, you will be required to complete a Statement of Health Form. Please call the Human Resources Benefits Office at (617) 627-3270 or go online to: http://www.tufts.edu/hr/bene to obtain a Statement of Health Form, which must be submitted directly to Prudential Insurance Company of America to apply for coverage.
HR Benefits Office Use Only Previous Coverage _____	HR Benefits Office Use Only Benefit Code _____

Dependent Life – Child(ren)

<input type="checkbox"/> No change <input type="checkbox"/> Enroll/change existing coverage (complete information below) <input type="checkbox"/> Waive Dependent Life Child(ren) Coverage (W)	Employee contribution required <input type="checkbox"/> \$10,000 (DC1)	HR Benefits Office Use Only Benefit Code _____
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Child(ren) Full Name	Relationship	Gender	Date of Birth

Dependent Life – Spouse/QDP

<input type="checkbox"/> No change <input type="checkbox"/> Enroll (complete information below) <input type="checkbox"/> Waive Dependent Life Spouse/QDP Coverage (W)	Employee contribution required <input type="checkbox"/> \$25,000 (DL1) <input type="checkbox"/> \$50,000 (DL2)	HR Benefits Office Use Only Benefit Code _____
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Spouse/QDP Full Name	Relationship	Gender	Date of Birth

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University Employee ID Number

Qualified Event

I understand the above and confirm that I experienced this change in status event on _____(date). The election change will become effective the date the Human Resources Benefits Office receives the completed form, except in the case of marriage, birth, death, adoption, and placement for adoption, in which case of the effective date is the date of the event. **Please check the appropriate box to verify that you have had a qualified change in status:**

QUALIFIED EVENT	REQUIRED DOCUMENTATION OF PROOF & EFFECTIVE DATE
<input type="checkbox"/> Marriage or the commencement of a QDP relationship;	Marriage Certificate or Statement of Domestic Partnership Election changes effective on: the date of the event.
<input type="checkbox"/> Divorce, legal separation, or termination of a QDP relationship;	Court Document or Statement of Termination of Domestic Partnership Election changes effective on: date we receive notification of the event.
<input type="checkbox"/> Birth, adoption or placement for adoption of your child;	Birth Certificate for new born child or completed Adoption Paperwork Election changes effective on: the date of the event.
<input type="checkbox"/> Death of a spouse/QDP or dependent;	Death Certificate Election changes effective on: the date of the event.
<input type="checkbox"/> Your covered dependent reaches the age limit for coverage;	Tufts University reserves the right to ask for documentation Election changes effective on: date we receive notification of the event.
<input type="checkbox"/> A move out of your health plan's service area;	Change of address form must be completed Election changes effective on: date we receive notification of the event.
<input type="checkbox"/> You, your spouse/QDP or eligible dependent begins or returns from an unpaid leave of absence;	Employer documentation is needed Election changes effective on: date we receive notification of the event.
<input type="checkbox"/> You, your spouse/QDP or eligible dependent has a change in job status that effects eligibility for coverage under a Tufts benefit plan or a plan of your eligible dependent's employer;	Employer documentation is needed Election changes effective on: date we receive notification of the event.

Other. Please explain:

PLEASE NOTE: When adding your spouse/QDP 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

PLEASE NOTE: When terminating your spouse/QDP 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 Qualified Same-Sex Domestic Partner ["QDP"]) that I have elected.
- After the effective date of this agreement, I will not be permitted to change my benefit elections until the new calendar 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 calendar 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 calendar 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 and have unpaid contributions for prior benefits coverage, I authorize Tufts University to deduct those unpaid amounts from my wages.
- I agree that the above information is accurate and true to the best of my knowledge.
- 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.

Print Employee Name Employee Signature Date HR Benefits Office Signature Date

Tufts University Status Change Guidelines

January 1, 2012

IRS regulations under Section 125 of the Internal Revenue Code require that once you have made your pre-tax elections for coverages, you may not change them during the enrollment year unless you have a qualifying change in status or other permissible event. If you request an election change, it must be on account of and correspond with the change in status. If you experience a change in status, or other permissible event, you must contact the Benefits Office within 31 days of the event; otherwise, you will need to wait until the next annual open enrollment period. The Plan Administrator reserves the right to review and interpret all requests for a benefit change due to a change in status or other permissible event.

Effective Date of Change

The election change will be effective the date the Human Resources Benefits Office receives the completed form, except in the case of marriage, birth, death, adoption, and placement for adoption, in which case of the effective date is the date of the event.

Qualified Changes in Status for the Flexible Spending Accounts, Health and Dental Plans

A qualified change in status will occur if you experience any of the following events:

- marriage or commencement of a Qualified Domestic Partner (QDP) relationship;
- divorce, legal separation, annulment or termination of a QDP relationship;
- birth, adoption or placement for adoption of your child;
- death of a spouse/QDP or dependent;
- your covered dependent reaches the age limit for coverage (26 years) making him or her ineligible for coverage;
- a move out of your health plan's service area;
- you, your spouse/QDP or eligible dependent begins or returns from an unpaid leave of absence;
- you, your spouse/QDP or eligible dependent has a change in job status that affects eligibility for benefit coverage under a Tufts plan or a plan of your spouse/QDP's or eligible dependent's employer.

Other Permissible Events

You may change your election to either provide health coverage or cancel health coverage for your dependent child under a Qualified Medical Child Support Order ("QMCSO") if the order stipulates that your plan or the other parent's plan must cover the dependent child.

If you, your spouse or eligible dependent becomes covered by Medicare or Medicaid, you may elect to cancel health coverage offered through Tufts for that individual.

If you, your spouse or eligible dependent is covered by either Medicare or Medicaid and subsequently loses coverage, you may elect health coverage offered through Tufts for that individual.

If a new health or dental benefit becomes available through Tufts (or an existing health or dental benefit is eliminated) during the plan year, or if a similar change occurs under a plan of your spouse/QDP's or eligible dependent's employer, you may elect the new coverage (or may elect another option if coverage has been eliminated), and may make corresponding election changes regarding similar coverage for the balance of the plan year. This provision does not apply to the Health Care Flexible Spending Account. However, if you are participating in the Dependent Care Flexible Spending Account, a change in your dependent care provider will be treated as a change in available coverage that will allow you to adjust your coverage level for the balance of the plan year.

If your share of the cost of health or dental coverage, or participation in the Dependent Care Flexible Spending Account, significantly increases or coverage is significantly curtailed, you may change your current election and elect similar coverage offered by Tufts for the balance of the plan year. Cost increases imposed by a day care provider who is your relative shall not be considered significant and your Dependent Care Flexible Spending Account election cannot be changed for the balance of the plan year on account of such increase.

If your spouse/QDP or eligible dependent makes an election change under a plan maintained by his or her employer, you may make an election change for the balance of the plan year that is on account of and corresponds with the election change made by your spouse/QDP or eligible dependent if either (a) the election change made by your spouse/QDP or eligible dependent under his or her employer's plan satisfies the cafeteria plan rules, or (b) the plan year of the plan maintained by your spouse/QDP's or eligible dependent's employer does not correspond with Tufts' calendar year plan year.

Federal Special Enrollment Rights

If you decline enrollment for yourself or your spouse or dependents because of other health (not dental) coverage, you may in the future be able to enroll yourself, your spouse or eligible dependents in one of the health options offered by Tufts, provided that you request enrollment within 31 days after the other health coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependants, provided that you request enrollment within 31 days after the event, even if the event is not considered a qualified change in status or is not consistent with the event. The plan administrator reserves the right to review and interpret all requests a special enrollment period.

To learn what specific changes are allowable given a particular event, or to initiate a change during the plan year, please contact the Human Resources Benefits Office at (617) 627-3270.