

# Tufts University Qualified Status Change



## Benefits Election Form And Salary Reduction Agreement

When participating in a Tufts University Medical, 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” (e.g. 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

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

**Medical 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 _____		

*\*Please Note: If you terminate medical 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.*

**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 medical, dental, or vision plans, including your legal spouse; qualified same-sex domestic partner; unmarried children to age 19; and unmarried children over age 19 but less than age 26 who are supported by the employee and are claimed by the employee as Federal Tax Dependents (Affidavit of IRS Dependent Status required). **Please circle Y or N to indicate enrollment in each plan.**

Last, First, MI	Medical	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 Medical 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

<b>Health Care Flexible Spending Account</b> <input type="checkbox"/> Enroll (H01) <input type="checkbox"/> Change Amount <input type="checkbox"/> No Change	<b>Amount of salary reduction \$ _____/calendar year</b> (To be divided evenly throughout the remainder of the calendar year. Not to exceed \$5,000 per year)
<b>Dependent Care Flexible Spending Account</b> <input type="checkbox"/> Enroll (H01) <input type="checkbox"/> Change Amount <input type="checkbox"/> No Change	<b>Amount of salary reduction \$ _____/calendar year</b> (To be divided evenly throughout the remainder of the calendar year. Not to exceed \$5,000 per year)
<i>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.</i>	

### 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

### 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)	<b>Employee contribution required</b>  <i>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: <a href="http://www.tufts.edu/hr/bene">http://www.tufts.edu/hr/bene</a> to obtain a <b>Statement of Health Form, which must be submitted directly to Prudential Insurance Company of America to apply for coverage.</b></i>
HR Benefits Office Use Only Previous Coverage _____	HR Benefits Office Use Only Benefit Code _____

**Dependent Life – Child(ren)** Important Note: To be eligible, you must be enrolled in Supplemental Life.

<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)	<b>Employee contribution required:</b> <input type="checkbox"/> \$10,000	HR Benefits Office Use Only Benefit Code _____
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Child(ren) Full Name	Relationship	Gender	Date of Birth

**Dependent Life – Spouse/QDP** Important Note: To be eligible, you must be enrolled in Supplemental Life.

<input type="checkbox"/> No change <input type="checkbox"/> Enroll (complete information below) <input type="checkbox"/> Waive Dependent Life Spouse/QDP Coverage (W)	<b>Employee contribution required</b> <input type="checkbox"/> \$25,000  <i>You may increase this coverage to \$50,000. See below for details.</i>	HR Benefits Office Use Only Benefit Code _____
<i>To enroll in Dependent Life (Spouse/QDP) Coverage at the \$50,000 level, 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: <a href="http://www.tufts.edu/hr/bene">http://www.tufts.edu/hr/bene</a> to obtain a <b>Statement of Health Form, which must be submitted directly to Prudential Insurance Company of America to apply for coverage.</b></i>		

Spouse/QDP Full Name	Relationship	Gender	Date of Birth



## **Tufts University Status Change Guidelines**

### **January 1, 2009**

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 enrollment. 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, 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, Medical and Dental Plans**

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

- marriage or commencement of a 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 effects 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 medical coverage or cancel medical 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 medical 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 medical coverage offered through Tufts for that individual.

If a new medical or dental benefit becomes available through Tufts (or an existing medical 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 medical 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 medical (not dental) coverage, you may in the future be able to enroll yourself, your spouse or eligible dependents in one of the medical options offered by Tufts, provided that you request enrollment within 31 days after the other medical 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.