

**NOTICE OF QUALIFYING EVENT OR OTHER COVERAGE CHANGE  
AND  
NEW ELECTION CHANGE**

**USE THIS NOTICE** to notify the Plan Administrator of Bird Island/Olivia/Lake Lillian School District # 2534 Flexible Benefits Plan of qualifying events or other status changes that affect benefit coverage **WHILE YOU ARE STILL EMPLOYED.**

**PLAN ADMINISTRATOR INFORMATION**

Name: Bird Island/Olivia/Lake Lillian School District # 2534  
Address: 701 South 9<sup>th</sup> Street  
Olivia, MN 56277

**COVERED EMPLOYEE INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Marital Status: \_\_\_\_\_

**Check the appropriate box** to indicate a Status Change or a Change in Cost of Coverage. One or more of the following events listed below may qualify you to change your coverage election during the Plan Year: Changes generally cannot be retroactive and must be made on account of and conform with the events indicated. As a general rule, the consistency requirement will not generally be met for a Status Change Event unless the event affects eligibility for the coverage sought to be changed under this Plan (or an employer-provided plan of your spouse or dependent). The Plan Administrator has final discretion to determine whether the eligibility requirement has been satisfied.

**Changes in Status**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>Change in Marital Status</b> | <input type="checkbox"/> Marriage         | <input type="checkbox"/> Divorce or Annulment |
|  | <input type="checkbox"/> Legal Separation | <input type="checkbox"/> Death of Spouse      |
  
- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> <b>Change in Number of Tax Dependents</b> | <input type="checkbox"/> Birth    | <input type="checkbox"/> Death of Dependent     |
|  | <input type="checkbox"/> Adoption | <input type="checkbox"/> Placement for Adoption |
  
- |  |                          |    |                          |                          |
|--|--------------------------|----|--------------------------|--------------------------|
| <input type="checkbox"/> <b>Change in Employment Status That Affects Eligibility</b> |                          |    |                          |                          |
|  | You                      | or | Your Spouse              | Dependent                |
| Termination of Employment  | <input type="checkbox"/> |    | <input type="checkbox"/> | <input type="checkbox"/> |
| Commencement of Employment   | <input type="checkbox"/> |    | <input type="checkbox"/> | <input type="checkbox"/> |
| Part-time to Full-time   | <input type="checkbox"/> |    | <input type="checkbox"/> | <input type="checkbox"/> |
| Full-time to Part-time   | <input type="checkbox"/> |    | <input type="checkbox"/> | <input type="checkbox"/> |
| Strike or Lock-Out   | <input type="checkbox"/> |    | <input type="checkbox"/> | <input type="checkbox"/> |
| Commencement of unpaid leave of absence  | <input type="checkbox"/> |    | <input type="checkbox"/> | <input type="checkbox"/> |
| Return from unpaid leave of absence  | <input type="checkbox"/> |    | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in Worksite   | <input type="checkbox"/> |    | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (Salaried to Hourly. etc.)   | <input type="checkbox"/> |    | <input type="checkbox"/> | <input type="checkbox"/> |
  
- |  |                          |
|--|--------------------------|
| <input type="checkbox"/> <b>Change in Spouse or Dependent's Eligibility Under an Employer's Plan</b> |                          |
| Loses eligibility (age, student status, marital status)  | <input type="checkbox"/> |
| Gains eligibility (age, student status, marital status)  | <input type="checkbox"/> |

**Please sign and complete the Reverse Side**

- |  |                              |  |
|--|------------------------------|--|
| <ul style="list-style-type: none"> <li>▪ <b>Change in Residence Affecting Eligibility</b></li> <li>▪ <b>Changes in Cost or Coverage</b><br/>[Note: Changes in Cost or Coverage do not allow for changes to your Med-X Account.]</li> <li>➤ <b>Significant Cost Increase In Your or Your Dependent's Coverage</b></li> <li>➤ <b>Significant Curtailment of Your or Your Dependent's Coverage</b></li> <li>➤ <b>Addition or Elimination of Benefit Package Option Under Your or Your Dependent's Employer's Plan</b></li> <li>➤ <b>Change in Coverage or Open Enrollment of Spouse or Dependent Under Other Employer's Plan</b></li> </ul> | You<br><input type="radio"/> | Your Spouse<br>or Dependent<br><input type="radio"/> |
|--|------------------------------|--|

Please explain the Status Change or Change in Cost or Coverage event(s) marked above on which you are basing your request for a mid-year coverage change and describe how the requested change is consistent with the event.

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I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with my employer's plan and the Plan Administrator has sole discretion to make this determination. If my change in participation is denied, I will have 60 days to appeal the decision.

**HEALTH PLAN(S) INFORMATION – IDENTIFICATION OF HEALTH COVERAGE BEING CHANGED:**

Plan Name: \_\_\_\_\_

Plan ID No.: \_\_\_\_\_

Type of coverage: \_\_\_\_\_

Level of coverage (single or family): \_\_\_\_\_

Effective \_\_\_\_\_, I hereby REVOKE my existing election under the Bird Island/Olivia/Lake Lillian School District # 2534 Flexible Benefits Plan.

**NEW ELECTION**

Effective \_\_\_\_\_, I hereby make a new election as specified on the attached Salary Reduction Agreement for the Bird Island/Olivia/Lake Lillian School District # 2534 Flexible Benefits Plan.

My revocation/new election is on account of and conforms with the Status Change rules or the change in cost of coverage.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Return this Election Form to:**  
  
**July Business Services – MN Division**  
**940 Industrial Drive South, Suite 111**  
**Sauk Rapids MN 56379**  
**Phone: 800-682-3826**  
**Fax: 866-374-7698**  
**Scan and email forms to:**  
[Cafeteria@julyservices.com](mailto:Cafeteria@julyservices.com)