



Qualifying Event Checklist

Employer Name

Employee Name

Job Title

Change in Legal Marital Status	Date of Change	Required Documents
<input type="checkbox"/> Marriage		Marriage certificate
<input type="checkbox"/> Divorce/Annulment		Divorce decree/Court ruling for annulment
<input type="checkbox"/> Legal separation		Court order verifying legal separation
<input type="checkbox"/> Death of spouse		Death certificate
Change in Number of Dependents	Date of Change	Required Documents
<input type="checkbox"/> Birth		Birth certificate
<input type="checkbox"/> Death		Death certificate
<input type="checkbox"/> Adoption/Placement for adoption		Court order for adoption/placement for adoption
Gain or Loss Eligibility for Other Group Coverage (HIPAA special enrollment)	Date of Change	Required Documents
<input type="checkbox"/> Group health plan		Documentation from plan or issuer regarding change in eligibility (with effective date)
Change in Employment Status of Employee or Spouse	Date of Change	Required Documents
<input type="checkbox"/> Loss of employment		Termination documents or unemployment application
<input type="checkbox"/> Start of employment		Employer documentation of employment start date
<input type="checkbox"/> Change in worksite		Employer documentation showing change and impact on eligibility
<input type="checkbox"/> Leave of absence		Employer documentation stating employee has commenced or returned from leave

Change in Place of Residence	Date of Change	Required Documents
<input type="checkbox"/> Change in place of residence of the employee, spouse or dependent that affects HMO eligibility		Documents indicating how change in residence affects employee eligibility
Entitlement to Medicare or Medicaid	Date of Change	Required Documents
<input type="checkbox"/> Employee, spouse or dependent becomes covered under Medicare or Medicaid or loses eligibility for his or her Medicare or Medicaid coverage (including coverage under a state Children's Health Insurance Program, or CHIP)		Government verification that coverage was gained or lost
Changes in Coverage	Date of Change	Required Documents
<input type="checkbox"/> Significant cost increases		N/A
<input type="checkbox"/> Significant curtailment of coverage		N/A
<input type="checkbox"/> Addition or significant improvement of benefits package option		N/A
<input type="checkbox"/> Change in coverage under other employer plan		Documentation from employer showing change in coverage
<input type="checkbox"/> Loss of health coverage sponsored by governmental or educational institution		Government verification of loss of eligibility
Other	Date of Change	Required Documents
<input type="checkbox"/> Change of custody, judgment, court order or decree requiring health coverage		Court documentation, including qualified medical child support order (QMCSO)
<input type="checkbox"/> COBRA qualifying event		N/A
<input type="checkbox"/> FMLA leave		N/A
<input type="checkbox"/> Eligibility for premium assistance subsidy through a Medicaid plan or CHIP		Government verification of eligibility for subsidy (with effective date)
<input type="checkbox"/> Exchange enrollment		Employee representation regarding enrollment in a plan under an Exchange
<input type="checkbox"/> Reduction in hours of service to less than 30 hours without loss of eligibility		N/A

Employee Signature

Date