



**NCFLEX PROGRAM**  
**2012 FAMILY/EMPLOYMENT STATUS CHANGE FORM**  
*Form must be completed within 30 days from the date of the event. Changes are effective the first of the month following the date of the event, with the exception of birth or adoption. Changes for a birth or adoption may be effective on the date of the event.*

www.ncflex.org

**SECTION A: EMPLOYEE INFORMATION**

Name (Last, First, MI)		Date of Birth		
Work Phone ( )		Social Security Number		
Street Address		City	State	Zip
<input type="checkbox"/> Check this box if your name or address has changed		Previous Name		

**SECTION B: TYPE OF FAMILY/EMPLOYMENT STATUS CHANGE (Check one)**

I incurred the family/employment status change event on the following date: \_\_\_\_\_

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Marriage                         | <input type="checkbox"/> Birth or adoption of child<br>(increase election only)                     | <input type="checkbox"/> Begin/End of spouse's employment   | <input type="checkbox"/> Begin unpaid leave of absence<br>(employee or spouse)                  |
| <input type="checkbox"/> Divorce                          | <input type="checkbox"/> Legal separation (must be<br>living apart from spouse at<br>least 90 days) | <input type="checkbox"/> Medicare/Medicaid  | <input type="checkbox"/> Return from unpaid leave of<br>absence (employee or spouse)            |
| <input type="checkbox"/> NC Health Choice<br>for Children | <input type="checkbox"/> Termination of employee's<br>employment or eligibility                     | <input type="checkbox"/> From full to part-time (less than 20<br>hrs/week) and vice versa (employee<br>or spouse) | <input type="checkbox"/> Significant change in health<br>coverage due to spouse's<br>employment |
| <input type="checkbox"/> Death of<br>spouse/child         | <input type="checkbox"/> Other (explain)<br>_____   | <input type="checkbox"/> Ineligible dependent, due to age,<br>marriage, or loss of full-time student<br>status    |   |

**Benefits Representative to Complete: employment changes that do not require benefit changes:**

- Transfer from agency/university/community college  
 9 – 10 month contractors  
 Last pay cycle for deduction: \_\_\_\_\_ Date employee returns to work: \_\_\_\_\_ Termination date: \_\_\_\_\_

**SECTION C: DEPENDENT CHANGE (Check all that apply)**

Name (Last, First, MI)	List applicable benefits	Gender		Date of Birth	Full-Time Student	Handicap
		M	F			
SPOUSE		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>
CHILD (1)		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>
CHILD (2)		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>
CHILD (3)		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>
CHILD (4)		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION D: DENTAL PLAN CHANGE**

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

- New Coverage     Change Coverage Level     Cancel Coverage    **Plan Option**     Low Option  
**Coverage Level**     High Option  
 Employee Only     Employee + One Child     Family  
 Employee + Two or more Children     Employee + Spouse

**SECTION E: VISION CARE PLAN CHANGE**

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

- New Coverage     Change Coverage Level     Cancel Coverage    **Plan Option**     Plan 1  
**Coverage Level**     Plan 2  
 Employee Only     Employee + Family     Plan 3

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

**SECTION F: CRITICAL ILLNESS**

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

New Coverage  Change  Cancel Coverage

**Coverage Level**

Employee Only  Employee + Spouse  Employee + Child(ren)  Employee + Family

**SECTION G: CANCER CHANGE**

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

You will need to submit an Evidence of Insurability Form if you are adding or increasing coverage. Visit [www.ncflex.org](http://www.ncflex.org) for EOI Forms.

New Coverage  Change  Cancel Coverage

**Plan Option**  Low Option  High Option  Premium Option

**Coverage Level**  Employee Only  Employee + Family

**SECTION H: VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CHANGE**

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

New Coverage  Change  Cancel Coverage

Aviation Pilot/Crew Member, after you select your coverage option, check this box:

**Plan Option**

Plan 1 Employee Only  Plan 2 Employee & Family

Insurance Amount \$ \_\_\_\_\_

Beneficiary Full Name	Mailing Address (Street, City, State, Zip)	Relationship to Employee	Date of Birth	Gender		% of Benefit
				M	F	
Primary:						
Contingent:						

**SECTION I: CORE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFICIARY CHANGE**

You may add Core AD&D coverage only if you are re-enrolling upon a return from leave of absence.

Changes to your beneficiary can be made at any time.

Re-enrolling from Leave  Change Beneficiary

Beneficiary Full Name	Mailing Address (Street, City, State, Zip)	Relationship to Employee	Date of Birth	Gender		% of Benefit
				M	F	
Primary:			/ /	<input type="checkbox"/>	<input type="checkbox"/>	
Contingent:			/ /	<input type="checkbox"/>	<input type="checkbox"/>	

**SECTION J: GROUP TERM LIFE CHANGE**

You will need to submit an Evidence of Insurability Form if you are adding or increasing coverage. Visit [www.ncflex.org](http://www.ncflex.org) for EOI Forms.

New Coverage  Change  Cancel Coverage Insurance Amount \$ \_\_\_\_\_

Beneficiary Full Name	Mailing Address (Street, City, State, Zip)	Relationship to Employee	Date of Birth	Gender		% of Benefit
				M	F	
Primary:			/ /	<input type="checkbox"/>	<input type="checkbox"/>	
Contingent:			/ /	<input type="checkbox"/>	<input type="checkbox"/>	

**SECTION K: FLEXIBLE SPENDING ACCOUNTS (NEW ANNUAL CONTRIBUTION AMOUNT) CHANGE**

Health Care FSA (Annual Min. \$120, Annual Max. \$5,000) **New Annual Contribution** \$ \_\_\_\_\_

Dependent Day Care FSA (Annual Min. \$120, Annual Max. \$5,000) **New Annual Contribution** \$ \_\_\_\_\_

Your **New Annual** Contribution should equal the total amount you would like to contribute to the FSA(s) as of 12/31 of the current plan year. Per pay contributions **equal**: new annual contribution **minus** total year-to-date contributions **divided by** the pay periods remaining for the year.

Cancel Health Care FSA  Cancel Dependent Day Care FSA  Cancel NCFlex Convenience Card

This is to certify that on the **family/employment status change event date in Section B**, I incurred the family/employment status change(s) checked in Section B, and wish to change my plan benefits as indicated on this form. I understand that the change must be consistent with the family/employment status change event and requested within 30 days of the event, and I might be required to provide documentation to my agency/university/community college benefit representative. I further understand that if my costs/contributions need to be caught up, they may be deducted from a future paycheck. **Note:** The IRS provides guidelines for the above family status changes and requires that you maintain legal documentation of the changes in your personal records. Examples of documentation include marriage, birth, or death certificates; divorce decrees; notice of legal separation; proof of change in spouse's employment; or adoption papers.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Benefit Representative to Complete		
Date Form Received _____	Payroll Center #(3 digits) _____	Prior Payroll Center #(3 digits) _____
Reviewed By _____	HBR Work Phone _____	

