# JCCC Qualified Status Change Form

## Employee Information

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>JCCC ID #</th>
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<tbody>
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<tr>
<td>Address</td>
<td>Phone #</td>
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</tbody>
</table>

## Event Date

- **ADD**
  - Marriage/Divorce
  - Declaration of domestic partnership
  - Birth/Adoption/Guardianship
  - Loss of other coverage
  - Change in dependent status
  - Qualified Medical Child Support Order

- **DROP**
  - Marriage/Divorce
  - Dissolution of domestic partnership
  - Gain of other coverage
  - Change in dependent status

This form and all supporting documentation must be received by HR within 30 days of the effective date of the change.

## Dependent Information

<table>
<thead>
<tr>
<th>First and Last Name</th>
<th>Relationship</th>
<th>Initials</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Action</th>
<th>Medical</th>
<th>Dental</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

## Requested Coverage Change

### Medical

- **Preferred-Care PPO**
- **Preferred-Care EPO**
- **Blue Saver HDHP**
- **A Healthier You**

### Dental

- **Delta Dental/PPO**
- **CIGNA Dental**

**If adding CIGNA Dental, please provide the name and Primary Dental Provider # for each covered participant. Add 2nd page if necessary.**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dentist Name</th>
<th>PDP #</th>
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</thead>
<tbody>
<tr>
<td>Employee Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Name</td>
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<td>Dependent Name</td>
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</tr>
</tbody>
</table>

### Vision

- **Eye Med**

### Health Care FSA

- **Increase**
- **Decrease**

### Dependent Care FSA

- **Increase**
- **Decrease**

### Health Savings Account

- **Increase**
- **Decrease**

### Optional Life Insurance

- **Increase** (Evidence of Insurability required)
- **Decrease**

### Dependent Life Insurance

- **Add** (Evidence of Insurability required for spouse)
- **Remove**
- **Spouse**
- **Children**
- **Spouse & Children**

Employee Signature

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