Anne Arundel County Public Schools | Division of Human Resources

Lifestyle Change Form for Healthcare Benefits

This form must be submitted within 31 days of a Qualifying Event. If adding or deleting dependents, please attach documentation *(e.g., proof of birth/adoption/marriage or divorce papers, proof of other insurance, etc.).*

Add Dependent(s)	Remove Dependent(s)	Change in Coverage
☐ Marriage *(opposite and same sex marriage recognized)* ☐ Birth/Adoption ☐ Other *(please explain)* *Please call with the child's SSN when it arrives.*	☐ Child over age 26 ☐ Dependent obtained other health insurance ☐ Divorce ☐ Death ☐ Other *(please explain)*	☐ Eligible for Medicare** ☐ Loss of other coverage ☐ Other *(please explain)*
Date of Event:	Date of Event:	Date of Event:

Your Name	First & Last Name of Doctor	Employee ID
Your Address	Work Location	
Date of Birth	Home Phone #	Work Phone #

Dependents Being Added or Removed *(For more dependents, please complete an additional Lifestyle Change Form)*

Spouse	SSN	Sex ☐ Male ☐ Female	Date of Birth	First & Last Name of Doctor
Child	SSN	Sex ☐ Male ☐ Female	Date of Birth	First & Last Name of Doctor
Child	SSN	Sex ☐ Male ☐ Female	Date of Birth	First & Last Name of Doctor
Child	SSN	Sex ☐ Male ☐ Female	Date of Birth	First & Last Name of Doctor

Change Level of Coverage *(Please note that with a lifestyle change, only a change in coverage level of insurance is allowed. You may only change insurance plans at Open Enrollment.)*

MEDICAL		DENTAL		VISION
☐ Blue Choice (HMO) Name of Doctor__________ ☐ Blue Choice Low Option (HMO) Name of Doctor__________ ☐ CareFirst Triple Option (HMO) Name of Doctor__________ ☐ CareFirst PPN *(grandfathered employees only)*	☐ Individual ☐ Parent/Child ☐ Employee/ Spouse ☐ Family	☐ PPO ☐ Traditional ☐ UCCI (HMO) Name of Dentist __________	☐ Individual ☐ Parent/Child ☐ Employee/ Spouse ☐ Family	☐ Individual ☐ Parent/Child ☐ Employee/ Spouse ☐ Family

**** Doctor's names must be provided for employees and dependents if enrolling in an HMO. Failure to provide these codes may result in delays in coverage.***

With a Qualifying Lifestyle Change, you may enroll, increase or decrease FSA or Voluntary Life Insurance Benefits.

Flexible Spending Account (FSA) – new election

Healthcare: $__________ Dependent Care: $__________
(Total $ election through end of this calendar year.)

Voluntary Life Insurance

If you wish to purchase or increase an existing policy, please submit a Voluntary Term Life Insurance Application, Evidence of Insurability, and a new Self-Administered Beneficiary Designation Form, also available on the AACPS website.

If newly eligible for Medicare**

Name	Medicare Number	Medicare Part A Effective Date	Medicare Part B Effective Date

***If you are an active employee and have a newly Medicare-eligible spouse or dependent covered under your plan, TEFRA requires the participant to remain on the active plan. Contact 410-222-5219/5221 for more information.*

I understand that all the information in this application is true and complete.

Signature *(Employee)*	Signature *(Spouse – for Medicare, if turning 65)*	Date

Return to: **Anne Arundel County Public Schools, HR/Benefits, 2644 Riva Road, Annapolis, MD 21401, fax: 443-458-0669, or email: benefits@aacps.org.**
Please make a copy for your records.