



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., birth certificate/adoption/marriage or divorce papers, proof of other insurance, etc.).

Add Dependent(s)	Remove Dependent(s)	Change in Coverage	Spousal Surcharge
<input type="checkbox"/> Marriage (<i>opposite and same sex marriage recognized</i>) <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Other (<i>please explain</i>) <i>Please call with the child's SSN when it arrives.</i>	<input type="checkbox"/> Child over age 26 <input type="checkbox"/> Dependent obtained other health insurance <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other (<i>please explain</i>)	<input type="checkbox"/> Eligible for Medicare* <input type="checkbox"/> Loss of other coverage <input type="checkbox"/> Other (<i>please explain</i>) <i>* 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>	<input type="checkbox"/> Applicable <input type="checkbox"/> Exempt; Spouse is: <input type="checkbox"/> unemployed <input type="checkbox"/> self-employed as a sole proprietor <input type="checkbox"/> a current AACPS employee or AACPS retiree <input type="checkbox"/> not eligible for healthcare coverage at his/her employer or their employer does not offer coverage <input type="checkbox"/> enrolled with the employee in the AACPS PPN or HMO Low Option plan
Date of Event:	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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	First & Last Name of Doctor
Child	SSN	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	First & Last Name of Doctor
Child	SSN	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	First & Last Name of Doctor
Child	SSN	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	First & Last Name of Doctor

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.

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
<input type="checkbox"/> Blue Choice (HMO) Name of Doctor _____ <input type="checkbox"/> Blue Choice Low Option (HMO) Name of Doctor _____ <input type="checkbox"/> CareFirst Triple Option (HMO) Name of Doctor _____ <input type="checkbox"/> CareFirst PPN <i>(grandfathered employees only)</i>	<input type="checkbox"/> PPO <input type="checkbox"/> Traditional <input type="checkbox"/> UCCI (HMO) Name of Dentist _____	<input type="checkbox"/> Individual <input type="checkbox"/> Parent/Child <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Family

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 <i>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.</i>
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I acknowledge that the information provided is true and accurate to the best of my knowledge. I further understand that falsifying information regarding my spouse's eligibility for medical coverage will result in, at a minimum, the application of a spousal surcharge in addition to any healthcare premium costs.

I understand that as a participant in an Anne Arundel County Public Schools (AACPS) benefit plan, any misrepresentation or omission of facts that is inconsistent with, and contrary to, the standards set for AACPS employees as established in the Employee Ethical Conduct section of the AACPS Employee Handbook may result in disciplinary action, including but not limited to, a reduction or loss of benefit, reversal of claim payments, and/or termination of employment.

Signature (Employee)	Date
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