NOTICE: Complete ONLY if canceling dependent coverage. Not applicable for retirees.

REVOKE ELECTION FORM

State Employees' Health Insurance Plan

Name: _____
(Please Print)

Contract No.: _____

Work Telephone: _____

Agency: _____

I certify that I have incurred the following change in status:

☐ Addition of dependent(s) through marriage, birth or adoption of a child, legal custody or placement for adoption;

☐ Loss of dependent(s) through divorce, annulment, legal separation, death of a spouse or other dependent, or loss of legal custody;

☐ Unpaid leave of absence for you or your spouse;

☐ Termination or commencement of your spouse's or dependent's employment;

☐ Change from full-time to part-time or part-time to full-time by the employee, spouse or dependent;

☐ Change from hourly to salaried payroll status or vice versa;

☐ Any other change in employment status not listed that results in the gain or loss of eligibility of the employee, spouse, or dependent;

☐ Dependent's loss of coverage due to age;

☐ Change of residence or worksite of employee, spouse or dependent;

☐ Compliance with issuance of family relations judgment, decree or order (i.e., QMCSO);

☐ Medicare or Medicaid entitlement of employee, spouse or dependent;

☐ Taking leave under the Family and Medical Leave Act;

☐ To make changes in the IRC Section 401(k) and 401(m) elective and after-tax deferrals as permitted by those sections;

☐ HIPAA special enrollment events;

☐ Significant change in medical benefits or premiums.

Date qualifying event occurred _____ (Must be within the last 30 days.)

Certification

I understand that federal regulations prohibit me from changing the election I have made after the beginning of the plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury.

I hereby certify that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature: _____ Date: _____

Employee E-mail Address:_____

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8341 / 1-866-836-9737 / FAX: 334-263-8541