Clear Form

POLK COUNTY
LIFE EVENT CHANGE FORM

EMPLOYEE INFORMATION

Name (Last, First, MI):	SSN or Employee Payroll ID:

LIFE EVENT

Date of Life Event _____

**Effective Date of coverage will be first of the month following the life event, except for Birth or Adoption which will begin on the event date.*

☐ **Marriage, reconciliation of legal separation** - *copy of marriage certificate required*
☐ **Divorce, legal separation** - *copy of page one of divorce decree required, plus page with judge's signature*
☐ **Birth or legal adoption of child** - *social security number needed once available / copy of adoption paperwork required*
☐ **Spouse gains employment or becomes eligible for benefits through employer** - *copy of new coverage with effective date required*
☐ **Spouse loses, or is no longer eligible for coverage -** *copy of loss/gain of coverage with effective date*
☐ **Child(ren) gains or loses other coverage** - copy of loss/gain of coverage with effective date required
☐ **Other:** _____

Medical	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children
Dental	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children
Vision	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children

FLEXIBLE SPENDING ACCOUNTS

MEDICAL REIMBURSEMENT ACCOUNT

☐ Enroll/ Change election

$_____ New Pay Period Deduction

☐ Waive Medical FSA

DEPENDENT CARE REIMBURSEMENT ACCOUNT

☐ Enroll/ Change election

$_____ New Pay Period Deduction

☐ Waive Dependent Care FSA

VOYA LIFE INSURANCE

Rates for life insurance can be found on the Employee Portal

☐ Add ☐ Drop $_____ Employee Supplemental Life*
☐ Add ☐ Drop $_____ Spouse Supplemental Life*
☐ Add ☐ Drop $ 10,000 Family Supplemental Life
☐ Add ☐ Drop $ 10,000 Child(ren) Supplemental Life

*Medical Underwriting required if adding or increasing life insurance for Employee or Spouse.

If you have Group Universal life insurance coverage through Principal, please call 515-286-3200 to obtain forms to update policy.

Spouse Information			
Last Name	First Name:	Middle Initial	Social Security Number
Date of Birth: (MM/DD/YYYY)	Gender	Relationship to Employee:	

Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop

Dependent Information:			
Last Name	First Name:	Middle Initial	Social Security Number
Date of Birth: (MM/DD/YYYY)	Gender	Relationship to Employee:	

Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop

Dependent Information:			
Last Name	First Name:	Middle Initial	Social Security Number
Date of Birth: (MM/DD/YYYY)	Gender	Relationship to Employee:	

Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop

Dependent Information:			
Last Name	First Name:	Middle Initial	Social Security Number
Date of Birth: (MM/DD/YYYY)	Gender	Relationship to Employee:	

Medical: ☐ Add ☐ Drop Dental: ☐ Add ☐ Drop Vision: ☐ Add ☐ Drop

ACKNOWLEDGEMENT

Please read carefully before signing this form:

I have indicated changes to my benefit elections and I understand that these changes will remain in effect until the next annual election period unless there is a change in my family status as defined by the Plan. I authorize Polk County to reduce my earnings by the amount of these elections or take deductions for the after tax elections. I authorize Human Resources to keep these elections in effect for any subsequent years (except FSA elections, which require me to re-enroll each plan year) unless I provide specific written notification in accordance with plan enrollment provisions.

Signature: **Date:**

APPROVED AND RECORDED BY HUMAN RESOURCES:

Health: ____________________ FSA: ____________________

Dental: ____________________ Payroll (JDE) ____________________

Vision: ____________________ Dependents (JDE) ____________________