City of Houston Benefits Qualifying Life Event Processing Form

611 Walker, 4th Floor, TX 77002 | 832-393-6000
benefits@houstontx.gov | cityofhoustonbenefits.org

Submit completed form to the Secure Document Portal at houstontx.gov/hr/benefits/sdsubmission_form.html

Please complete and return the attached Qualifying Life Event Processing form and the required supporting documentation listed on page 2 within 31 days of your qualifying life event.

Submit this form, along with your documentation through one of the following methods:
Benefits Secure Documents Portal: http://www.houstontx.gov/hr/benefits/sdsubmission_form.html
Email: benefits@houstontx.gov
Walk-in: 611 Walker, 4th Floor, Houston, Texas 77002; Attn: HR Benefits

If you do not submit these documents timely (within 31 days of your qualifying life event), your Human Resources Benefits team will not be able to process your benefits elections. The next opportunity to process elections will be the next Open Enrollment.

Total Number of pages):_____ **Date of Qualifying Event:**_____

Employee Name	Employee ID	Phone Number	Email

Address	City	State	Zip

Qualifying Life Event: Check the appropriate option below.

☐ Birth ☐ Adoption/Court Order ☐ Marriage ☐ Divorce
☐ Lost or Obtained Health Coverage ☐ Drop Grandchild ☐ Death
☐ Drop Child over the age of 18 ☐ Other:_____

Requested Action: Check the appropriate option below.

☐ Coverage Termination ☐ Coverage Enrollment

Benefit(s) Impacted: Check all that apply.

☐ **Medical** (Select a plan)
- ☐ Open Access Plan
- ☐ CDHP
- ☐ Limited Network (Select a physician's network)
  - ☐ Kelsey-Seybold
  - ☐ Renaissance - Physician ID _____
  - ☐ Village Family Practice - Physician ID _____

○ Employee Only
○ Employee + Child(ren)
○ Employee + Spouse
○ Employee + Family

☐ **Dental** (Select a plan)
- ☐ DHMO
- ☐ DPPO

○ Employee Only
○ Employee + 1
○ Employee + 2 or more

☐ **Vision**

○ Employee Only
○ Employee + Child(ren)
○ Employee + Spouse
○ Employee + Family

Employee or Dependents Impacted: Complete for all applicable.

First Name	Middle Initial	Last Name	Date of Birth	Social Security No.	Relationship	Medical		Dental		Vision		Tobacco User*
						Add	Drop	Add	Drop	Add	Drop	
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐	☐

***Non-tobacco User Discount -** If you and/or your dependents do not use tobacco products, you qualify for the monthly non-tobacco user discount of $35 per non-tobacco user. If you and/or any of your dependents indicated tobacco use, you will not be eligible for the non-tobacco user discount. By enrolling and participating in a smoking/tobacco cessation program, you may become eligible for the monthly non-tobacco user discount of $35 per participant. In order to be eligible for the discount, previously indicated tobacco users on the medical plan must participate in a smoking cessation program. Smoking/tobacco cessation programs must be facilitated or validated by the City of Houston.

Supporting Documents Required to Change Coverage as a Result of a Qualifying Event			
Newborn	**Marriage**	**Divorce**	**Lost or Obtained Medical Coverage**
☐ Verification of Birth Facts (Until age 3 months only) ☐ Social Security Number/ITIN (within 60 days)	☐ Marriage Certificate (front) ☐ Marriage Certificate (back) ☐ Social Security Number/ITIN	☐ Copy of Divorce Decree	☐ Letter of Creditable Coverage
☐ **Drop Child/Grandchild/Stepchild Over 18**		☐ **Drop Grand/ Stepchild** (if they do not qualify as your dependents for federal income-tax purposes and do not live with you)	
☐ **Other** *Please contact Benefits Division (832-393-6000 or benefits@houstontx.gov)		☐ No support needed	

***Note:** Dependents over age 18 for whom an active Medical Support Order or Court Order is on file will not be able to be dropped from the plan unless Termination of Medical Support Order or Termination of Court Order documents are provided

If you are adding Dependent Coverage due to a Qualifying Life Event, please submit the above listed Required Supporting Documentation along with the below listed Required Supporting Documentation to add a Dependent.

Required Supporting Documents to Add Dependent Coverage
All necessary documents as identified below must be submitted and verified before dependents can be covered under any City of Houston benefits plans. Some of the submitted documents must be County Clerk certified or court-filed documents. Each submitted document will be reviewed by the Benefits Division for approval before processing changes to coverage.

Legal Spouse	Biological Children (under age 26)	Stepchildren (under age 26)	Biological Grandchildren* (under age 25)	Adopted/Court Ordered Dependents
☐ Social Security Number/ITIN ☐ Marriage Certificate (front) ☐ Marriage Certificate (back) **OR** ☐ Social Security Number/ITIN ☐ Declaration of Registration of Informal Marriage (Common Law)	☐ Social Security Number/ITIN ☐ Birth Certificate **OR** ☐ Social Security Number/ITIN ☐ Verification of Birth Facts (Until age 3 months only)	☐ Social Security Number/ITIN ☐ Birth Certificate ☐ Marriage Certificate (front) ☐ Marriage Certificate (back)	☐ Social Security Number/ITIN ☐ Current IRS Filing ☐ Birth Certificate of Grandchild ☐ Birth Certificate of Grandchild's Natural Parent/ Employee's Biological Child ***step-grandchildren are not eligible for coverage***	☐ Social Security Number/ITIN ☐ Adoption/Guardianship Documents ☐ Birth Certificate **OR** ☐ Social Security Number/ITIN ☐ Custody/Court Order Documents ☐ Birth Certificate

Note: Eligible Dependent - An eligible dependent is your legal spouse and any child (natural, adopted, foster, grandchild, stepchild, and a child for whom you are legal guardian and/or have legal support obligation) who is your dependent for federal income tax purposes, resides with you, and is under age 26 or under age 25 for grandchild(ren).

Disabled children age 26 and over - Child must be primarily supported by you, and incapable of self-sustaining employment by reason of mental incapacity, physical disability or handicap, which arose while the child was covered as a dependent on a city plan without a break in coverage. Upon applying and receiving third party medical administrator's approval, proof of the child's condition and dependence must be submitted within 31 days or the child ceases to qualify for benefits.

Important - If both you and your spouse work(ed) for the city, you may be covered as an employee/retiree or as a dependent - but not both. Dependents may be enrolled under only one parent or guardian.

I hereby certify that the dependent(s) listed above is/are my dependent(s) as defined by the Internal Revenue Service and as defined in the City of Houston Health Benefits plans. I further certify that the information and all supporting documentation submitted with this application or in the future in connection herewith is true and correct. Any misrepresentation (overt or by omission) may be considered a fraudulent act. Therefore, any fraudulent act or refusal to provide the documentation required shall be grounds for denial of coverage or refusal or rescission of coverage applicable to the dependent(s) for whom the misrepresentation relates. Neither, the insurance carrier, the City of Houston or the plan administrator will have further liability or obligation to cover the expenses of such dependent(s). The City of Houston or carrier would also be entitled to recover any expenses incurred and improperly paid by it by reason of such misrepresentation. This certification is made under penalty of perjury for the consideration and purpose of obtaining benefits for said dependent(s) designated on this form.

Employee Authorization of Payroll Deductions

I am an employee of the City of Houston, eligible to participate in the medical and dental and vision program. I apply to participate and understand that the information I have provided above is part of my application. All statements made by me may be relied upon by the city. If any information that I have provided is found to be materially incorrect, my coverage may be denied. I realize that any medical coverage I or my dependents are eligible for at this time, which I decline, may be available in the future if I provide proof of a change in family status within 31 days of family status change.

I agree that if I have listed ineligible dependents, my medical coverage may be canceled. I authorize the City of Houston to deduct from my wages or salary my portion of the contribution as it becomes due. I understand that I must notify the City of Houston when I have an ineligible dependent, and that I may receive a refund of premiums paid for an ineligible dependent for up to two months. I will be responsible for any and all medical, dental and vision claims paid on an ineligible dependent.

Print Employee Name: _____ Employee Signature: _____

Date: _____ Employee ID#: _____

For Internal Use Only

Received by: _____ Processed by:_____ QC Review by: _____

Date: _____ Date:_____ Date:_____