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

REVOKE ELECTION FORM
State Employees' Health Insurance Coverage

Name: _____ Contract #: _____
(Please Print)

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: 334-517-9728