QUALIFYING LIFE EVENT FORM

Eligibility Approved by
Date
Effective Date
Processed by
Date

Return Form to:
DHR Insurance Division
68 Mitchell St SW
Suite 2120
Atlanta GA 30303

USE THIS FORM TO ATTACH ANY REQUIRED DOCUMENTATION OR TO MAKE ENROLLMENT CHANGES.

Employee/Retiree Information (REQUIRED)

Last Name	First Name	Social Security Number	Telephone
Address	City/State	Zip Code	Department (Active Employees)
Active ☐ Retiree ☐	Fire ☐ Police ☐	General Fund ☐	

Current Enrollment or New Elections

Medical	**Dental**	**Vision**	**Dependent Life**
BCBS POS ☐	Cigna PPO High ☐	OptumHealth ☐	Greater GA Life ☐
BCBS Anthem Medicare PPO ☐	Cigna PPO Low ☐		
Kaiser HMO ☐	Humana Dental Access ☐		
Retiree Kaiser Sr. Adv. ☐	Humana Pre-Select ☐		

Change My Enrollment as Indicated Below: Dependent Information

Last Name, First Name	Sex	Social Security Number	Date of Birth	MED		DEN		VIS		DEP LIFE	
				Add	Drop	Add	Drop	Add	Drop	Add	Drop

IMPORTANT: Any Dependent listed above must meet eligibility requirements listed in the Enrollment Guide. Eligible Dependents are: Your Spouse/Domestic Partner and children 26 and under. Documentation is required to add or delete dependents. Please see enrollment guide for requirements. If you do not enroll your dependent(s) within **31 days** of the qualifying life event then the next opportunity to enroll your dependents will only be during the Open Enrollment Period to be effective the following plan year.

Reason for Add/Continue Coverage	**Date of Life Event**	**Reason for Drop (indicate below)**	**Date of Life Event**
Newborn ☐ DOB		Ineligible Dependent ☐	
Marriage ☐ Domestic Partner ☐		Divorce/Term Domestic Partnership ☐	
Add A Child ☐ Disabled Child ☐		Dependent Obtained Coverage ☐	
Add Dependent Loss of Coverage (**You must provide a Certificate of Credible Coverage)** ☐		Deceased Dependent ☐	

EMPLOYEE/RETIREE ACKNOWLEGEMENT & AUTHORIZATION

My signature below authorizes the City of Atlanta to deduct from my compensation any and all newly elected and or existing plan contributions for the above dependent(s). I acknowledge that by electing coverage for this dependent(s), I am authorizing deductions with respect to my benefits to remain in effect at least until the next Open Enrollment period or until I am able to make a change to my benefits as a result of a qualifying life event(s).

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Employee/Retiree Signature Date

FORM DHR_INS_CHG **If you need assistance completing this form contact DHR Insurance Division 404.330.6036**