Office of State PERSONNEL NCFLEX

NCFLEX PROGRAM
2008 FAMILY/EMPLOYMENT STATUS CHANGE FORM

www.ncflex.org

Form must be completed within 30 days from the date of the event. Changes are effective the first of the month following the date of the event, with the exception of birth or adoption. Changes for a birth or adoption are effective on the date of the event.

SECTION A: EMPLOYEE INFORMATION

Name (Last, First, MI)		Date of Birth		
Work Phone ( )		Social Security Number		
Street Address		City	State	Zip
☐ Check this box if your name or address has changed	Previous Name			

SECTION B: TYPE OF FAMILY/EMPLOYMENT STATUS CHANGE (Check one)

☐ Marriage	☐ Birth or adoption of child (increase election only)	☐ Begin of spouse's employment ☐ End of spouse's employment	☐ Begin unpaid leave of absence (employee or spouse)
☐ Divorce	☐ Legal separation (must be living apart from spouse at least 90 days)	☐ From full to part-time (less than 20 hrs/week) and vice versa (employee or spouse)	☐ Return from unpaid leave of absence (employee or spouse)
☐ Death of spouse	☐ Termination of employee's employment or eligibility	☐ Ineligible dependent, due to age, marriage, or loss of full-time student status	☐ Significant change in health coverage due to spouse's employment
☐ Death of dependent child	☐ Other (explain) _____		

Benefits Representative to Complete: employment changes that do not require benefit changes:

☐ Transfer from agency/university/community college

☐ 9 – 10 month contractors

Last pay cycle for deduction: _____ Date employee returns to work: _____ Termination date: _____

SECTION C: DEPENDENT CHANGE (Check all that apply)

Name (Last, First, MI)	List applicable benefits	Gender M	Gender F	Date of Birth	Full-Time Student	Handicap
SPOUSE		☐	☐	/ /	☐	☐
CHILD (1)		☐	☐	/ /	☐	☐
CHILD (2)		☐	☐	/ /	☐	☐
CHILD (3)		☐	☐	/ /	☐	☐
CHILD (4)		☐	☐	/ /	☐	☐
CHILD (5)		☐	☐	/ /	☐	☐

SECTION D: DENTAL PLAN CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ Add Coverage (attach completed enrollment form) Monthly Cost $_____

☐ Add/Drop Coverage (for dependent(s) listed in Section C) Monthly Cost $_____

☐ Cancel Coverage

SECTION E: VISION CARE PLAN CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ Add Coverage (attach completed enrollment form) Monthly Cost $_____

☐ Add/Drop Coverage (for dependent(s) listed in Section C) Monthly Cost $_____

☐ Change in Plan (requires approval)

☐ Cancel Coverage

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www.ncflex.org

Name: _____ **SSN:** _____

SECTION F: CANCER CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

You will need to submit an Evidence of Insurability Form if you are adding or increasing coverage. Visit www.ncflex.org for EOI Forms.

☐ Add Low Option (Employee Only)
☐ Add High Option (Employee Only)
☐ Add Low Option (Employee & Family)
☐ Add High Option (Employee & Family)
☐ Change in Plan
☐ Cancel Coverage Monthly Cost $ _____

SECTION G: ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ Add Plan 1 (Employee Only)
☐ Add Pilot—Plan 1 (Employee Only)
☐ Add Plan 2 (Employee & Family)
☐ Add Pilot—Plan 2 (Employee & Family)
☐ Change in Plan
☐ Cancel Coverage

Insurance Amount _____ Monthly Cost $ _____

Beneficiary Full Name	Mailing Address (Street, City, State, Zip)	Relationship to Employee	Date of Birth	Gender M	Gender F	% of Benefit
Primary:			/ /	☐	☐	
Contingent:			/ /	☐	☐	

SECTION H: GROUP TERM LIFE CHANGE

You will need to submit an Evidence of Insurability Form if you are adding or increasing coverage. Visit www.ncflex.org for EOI Forms.

☐ Add Coverage
☐ Cancel Coverage
☐ Change in Coverage Amount

Insurance Amount _____ Monthly Cost $ _____

Beneficiary Full Name	Mailing Address (Street, City, State, Zip)	Relationship to Employee	Date of Birth	Gender M	Gender F	% of Benefit
Primary:			/ /	☐	☐	
Contingent:			/ /	☐	☐	

SECTION I: FLEXIBLE SPENDING ACCOUNTS (NEW ANNUAL CONTRIBUTION AMOUNT) CHANGE

☐ Health Care FSA (**Annual** Min. $120, **Annual** Max. $4,200) **New Annual** Contribution $_____

☐ Dependent Day Care FSA (**Annual** Min. $120, **Annual** Max. $5,000) **New Annual** Contribution $_____

Your **New Annual** Contribution should equal the total amount you would like to contribute to the FSA(s) as of 12/31 of the current plan year.
Per pay contributions **equal**: new annual contribution **minus** total year-to-date contributions **divided by** the pay periods remaining for the year.

☐ Cancel Health Care FSA
FSA Reimbursement by Direct Deposit:
☐ Cancel Dependent Day Care FSA
☐ Decline ☐ Reinstate
☐ Cancel NCFlex Convenience Card

This is to certify that on the **event date below**, I incurred the family/employment status change(s) checked in Section B, and wish to change my plan benefits as indicated on this form. I understand that the change must be consistent with the family/employment status change event and requested within 30 days of the event, and I might be required to provide documentation to my agency/university/community college benefit representative. I further understand that if my costs/contributions need to be caught up, they may be deducted from a future paycheck. **Note:** The IRS provides guidelines for the above family status changes and requires that you maintain legal documentation of the changes in your personal records. Examples of documentation include marriage, birth, or death certificates; divorce decrees; notice of legal separation; proof of change in spouse's employment; or adoption papers.

Employee Signature _____ Date _____ Date of Event _____

Benefit Representative to Complete

Date Form Received _____ Payroll Center #(3 digits) _____ Prior Payroll Center #(3 digits) _____

Reviewed By _____ HBR Work Phone _____

FORM 2 **Please make a copy for your records then return completed ORIGINAL form to your Benefits Representative.** **REV: 11/07**