Service ______

BROWN UNIVERSITY - BENEFITS OFFICE

Change of Status Form: BROWN FLEX

Last name, First name, Middle Initial | Social Security Number | Org | Ben Group | Emp. Type

Address | Phone (campus or home) | Ben % | Pay Sched.

Reason for Change

Date of Event ______ ***Documentation must be provided for all requested changes.***

❒ Birth ❒ Adoption* ❒ Marriage* ❒ Divorce* ❒ Death* ❒ Loss of coverage*

❒ Change from f/t to p/t employment (employee or spouse) or vice versa* — from ______ % to ______ %

❒ Commencement/termination of employment (spouse)* ❒ Other or spouses open enrollment period

❒ Post tax change ❒ Paid to unpaid appointment

Change Request

❒ Health Coverage From: ______ Plan ______ Coverage To: ______ Plan ______ Coverage ______ Effective Date

❒ Dental Coverage From: ______ Plan ______ Coverage To: ______ Plan ______ Coverage ______ Effective Date

❒ DCAP Total Annual Goal Amount From: $ ______ To: $ ______ ______ Effective Date

❒ MRP Total Annual Goal Amount (for FMLA only) From: $ ______ To: $ ______ ______ Effective Date

NOTE: New enrollment form required to elect coverage or change levels of coverage; carrier change form may be required for other changes.

I understand that I must notify the Benefits Office of my change in status within 31 days of the date of the event. In addition, I certify that the above information is correct and understand that, by law, I cannot effect a change in my Brown Flex election(s) unless I have a qualified status change as defined by the Brown University Flex Plan Documents. **I understand that I must provide documentation to substantiate all specified status change requests.**

Employee's Signature ______ Date ______

Dependent Information

Last name, First name, Middle Initial | Social Security Number | Date of Birth

Last name, First name, Middle Initial | Social Security Number | Date of Birth

Signoff/date ______

BENEFITS ACTION - For Benefits Use Only

❒ Health Carrier ______ Effective date ______ Action ______

❒ Dental Effective date ______ Action ______

❒ Group Life Effective date ______ Action ______

❒ LTD Effective date ______ Action ______

❒ Retirement Effective date ______ Action ______

❒ SPD's sent Effective date ______ Action ______

OTD/Ref/BO Pay Adjust PPE ______ GTN ______ $$ ______ GTN ______ $$ ______

OTD/Ref/BO Pay Adjust PPE ______ GTN ______ $$ ______ GTN ______ $$ ______

Notes/Comments:

Signoff/date ______

HRMS Operations Update Screens

❒ 01/003 status ❒ 03/028 retirement; MEA ❒ 01/005 phone ❒ 01/006 address ❒ 01/018 LOA update

❒ 03/002 health; life; ltd ❒ 03/011 dental; mmed; ltc ❒ 03/014 dep. ❒ 03/015 COBRA

❒ Crosby; dependent drop (if no term date)

Notes/Comments:

Signoff/date ______