HUMAN RESOURCES DEPARTMENT – BENEFITS SECTION
CITY OF FORT LAUDERDALE BENEFITS CHANGE FORM

Rev: 3 | **Date:** 12/30/2025 | **Print Date:** 12/30/2025

Per Section 125 of the Internal Revenue Code the Benefits Section must receive this completed form within 30 days from the date of the qualifying life event (60 days for newborns, adoptions/placements for adoption or Certain Special Enrollment Rights). Change requests received after the applicable 30- or 60-day time limit will **NOT** be processed.

Submit supporting documentation as soon as available to:
healthyliving@fortlauderdale.gov or FAX: 954-828-5328

Employee Last Name (Print)	Employee First Name (Print)	Employee ID Number
Email	**Work Phone**	**Cell Phone**
Date of Qualifying Life Event		

PLEASE INDICATE THE TYPE OF MID-PLAN YEAR EVENT INCURRED.

Permitted Qualifying Life Events (Mid-Plan Year Changes)*	Required Documentation
☐ Loss of coverage for (dependent) child or spouse	Letter of explanation from Employer or insurance company with cancellation date of coverage/ Discharge paper
☐ Gain of coverage for (dependent) child or spouse	Letter of explanation from Employer or insurance company with start date of coverage/ enlistment papers.
☐ Marriage/Domestic Partner (DP)	Marriage Certificate or Domestic Partner Affidavit
☐ Divorce/Termination of Domestic Partnership (DP)	Divorce decree or Letter from employee stating they are terminating their Domestic Partnership with the name of their DP and the termination effective date included
☐ Death (dependent) child or spouse/DP	Death certificate
☐ Adoption/ Birth of a child* (60 days for newborns)	Birth certificate (when it becomes available) / Finalized Adoption agreement or letter from placement agency
☐ Significant change in health coverage due to spouse's or dependent's employment*	Letter of explanation from employer or insurance company
☐ Court Order*	Court Order
☐ Medicare ☐ SELF ☐ SPOUSE	Copy of Medicare card showing effective date or another form of documentation showing effective date of coverage
☐ Medicaid*/CHIP ☐ SELF ☐ SPOUSE ☐ DEPENDENT	Copy of Medicaid/CHIP card or relevant letter indicating effective date

PLEASE INDICATE THE DEPENDENTS YOU WISH TO ADD/DROP COVERAGE FOR THE MID-PLAN YEAR EVENT INDICATED ABOVE.

LAST NAME	FIRST NAME	SOCIAL SEC #	Date of Birth MM/DD/YYYY	Gender M / F	Relationship
					Spouse/DP
					Child
					Child
					Child
					Child
					Child

Approved by: Jerome Post, Director of Human Resources
Uncontrolled in hard copy unless otherwise marked

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PLEASE INDICATE THE CHANGES YOU WISH TO MAKE DUE TO THE MID-PLAN YEAR EVENT INDICATED ABOVE PERMITTED ELECTION CHANGES MUST BE CONSISTENT WITH THE EVENT.*

Group Medical Insurance (Pre-Tax)	Group Dental Insurance (Pre-Tax)	Group Vision Insurance (Pre-Tax)
Choose Plan: ☐ CDHP ☐ HMO1 ☐ HMO2 ☐ Terminate coverage ☐ Change to Single coverage ☐ Change to Employee + Spouse/DP ☐ Change to Employee + Child ☐ Change to Employee + Children ☐ Change to Family coverage ☐ No change in premium. Add/Delete Dependent	Choose Plan: ☐ DHMO ☐ DPPO ☐ Terminate coverage ☐ Change to Single coverage ☐ Change to Employee + Spouse/DP ☐ Change to Employee + Child(ren) ☐ Change to Family coverage ☐ No change in premium. Add/Delete Dependent	Choose Plan: ☐ Core Plan ☐ Buy up Plan ☐ Terminate coverage ☐ Change to Single coverage ☐ Change to Employee + Spouse/DP ☐ Change to Employee + Child(ren) ☐ Change to Family coverage ☐ No change in premium. Add/Delete Dependent
Healthcare Spending Account* (Pre-Tax)	**Dependent Care Spending Acct. (Pre-Tax)**	**Group Legal Insurance (Post-Tax)**
☐ Terminate coverage ☐ Change existing coverage amount: _____	☐ Terminate coverage ☐ Change existing coverage amount: _____	☐ Terminate coverage
Group Accident Insurance (Pre-Tax)	**Group Hospital Indemnity (Post Tax)**	**Group Critical Illness (Pre-Tax)**
☐ Terminate coverage ☐ Change to Single coverage ☐ Change to Employee + Spouse/DP ☐ Change to Employee + Child ☐ Change to Employee + Children ☐ Change to Family coverage	☐ Terminate coverage ☐ Change to Single coverage ☐ Change to Employee + Spouse/DP ☐ Change to Employee + Child ☐ Change to Employee + Children ☐ Change to Family coverage	☐ Terminate coverage ☐ Change to Single coverage ☐ Change to Employee + Spouse/DP
Group Employee Term Life Insurance (Post-Tax) Increments of $5,000 up to a max of $400,000; **may be subject to EOI****	**Group Spouse/DP Term Life Insurance (Post Tax)** Increments of $500 up to a max equal to employee coverage; **may be subject to EOI****	**Group Child(ren) Term Life Insurance (Post-Tax)** May be enrolled for $10,000 of coverage; **employee must also be enrolled in voluntary term life****
☐ Terminate coverage ☐ Start coverage amount: _____ ☐ Change existing coverage amount: _____	☐ Terminate coverage ☐ Start coverage amount: _____ ☐ Change existing coverage amount: _____	☐ Terminate coverage ☐ Start coverage amount: _____
Short Term Disability (Post-Tax) cannot exceed 60% of the employee base annual pay	**Pet Discount Bundle (Post-Tax)**	**Cancer Support Program (Post-Tax)**
☐ Terminate coverage ☐ Start coverage amount: _____	☐ Terminate coverage ☐ Start coverage: _____	☐ Terminate coverage ☐ Start coverage: _____
Beyond Med (Post-Tax)		
☐ Terminate coverage ☐ Start coverage: _____		

This is to certify that I incurred the events indicated above and therefore wish to modify my benefits and salary reduction amounts as indicated. I understand that the change(s) requested must be consistent with the event and that I must provide documentation of all events. If documentation is not readily available, submit this form within 30 days (60 days for newborns and/or adopted children) of the event and forward documentation as soon as available. **REVIEW OF ALL REQUESTS WILL BE PENDING RECEIPT OF DOCUMENTATION.**

Signature _____ Date _____

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The benefits elections you make are generally irrevocable during the Plan Year. This means that once you have enrolled in benefits, you are locked into that election until the next annual enrollment period. However, under Section 125 of the Internal Revenue Code there are certain situations, known as qualifying life events, that allow you to change your benefits outside of the annual Open Enrollment period. **Mid-year plan election changes must be consistent with the event.**

Upon the approval and completion of processing your election change request, the deductions for your existing benefit election(s) will be stopped or modified (as appropriate). Changes to add a new dependent become effective the first of the following month providing receipt of a timely request with the exception of birth or an adoption of a child. Payroll changes to add a newborn are processed in accordance with Florida Statute 641.31(9). Generally, mid-year plan pre-tax election changes can only be made prospectively.

1. **Gain or loss of dependents eligibility status** – An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include a change in age or employment status.
2. **Dependents Eligibility Status** – The Patient Protection and Affordable Care Act (PPACA) extended the limiting age for dependent children (medical only) to when the dependent turns age 26. Marital status, financial dependency, or student status are no longer applicable. Consequently, you cannot remove a dependent child from coverage due to marriage, or initial employment, unless the child gains other group insurance and enrolls in it. Moving out of the employee's home and losing financial dependency on the parent are not QEs that would permit the dependent's coverage to be canceled.

   Florida Statute Chapter 627.6562 stipulates that for dependent children ages 26-30 to be eligible for group medical coverage they must be (a) unmarried without any dependents, (b) a resident of Florida or a full-time/part-time student and (c) is not provided coverage or is not a covered person under any other group medical insurance policy or individual medical benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act. Certification must be completed upon initial enrollment and annually thereafter.
3. **Special Enrollment Provisions** – Except for your employer's health FSA plan, your employer's group health plans are subject to Special Enrollment Rights which provide that an IRC125 cafeteria plan may permit an employee to change a salary reduction election due to birth or an adoption of a child.
4. **Child Health Insurance Program Reauthorization Act (CHIPRA)** amends the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act to require employer- sponsored group health plans to permit employees or their dependents to enroll in the plan if they lose eligibility for Medicaid or CHIP, or if they become eligible for premium assistance under Medicaid or CHIP. An individual who requests enrollment within 60 days of losing or becoming eligible for Medicaid or CHIP must be enrolled even if there is no open enrollment period, and without any penalties for late enrollment.

Return Completed Form To:

The Benefits Section/Human Resources Department
Address: 101 NE 3rd Avenue.,16th Floor Fort Lauderdale, FL 33301
Phone: 954-828-5160 Fax: 954-828-5328
Email: healthyliving@fortlauderdale.gov

Please keep a copy of the completed form for your records.

Approved by: Jerome Post, Director of Human Resources
Uncontrolled in hard copy unless otherwise marked

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