

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: (_____) _____ Ext: _____ 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 or student's status;
- _____ 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: _____

**STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8341 / 1-866-836-9737 / FAX: 334-263-8541**