HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN	STATUS CHANGE FORM **Please print neatly in ink**
Name:	
SSN:	Telephone No.:
Address:	

You may change your elections under the Plan during a period of coverage if you experience a "status change", if you have a "special enrollment right" or under certain other circumstances. For status change elections (Part A below), the election change must be consistent with that Status Change. Please complete Part A below if you believe you have experienced a Status Change and want to change your coverage under the Plan, in a manner that is consistent with that Status Change.

Complete Part B below if you believe you have a "special enrollment right", as described in your Summary Plan Description. The election changes that are permitted because of a special enrollment right vary depending on the type of special enrollment right you experience. Generally, you may enroll any eligible person who loses eligibility for other coverage or any eligible person who becomes your spouse or dependent because of marriage, birth or adoption. If you believe you have experienced both a status change and a special enrollment right, you should complete both Part A and Part B.

Complete Part C below if you want to change your election because of certain other changes described in Part C if the change you desire is consistent with a change described in Part C. Whether you complete Part A, Part B or Part C, you must sign at the bottom of Page 2.

The Employer may require additional information regarding certain types of changes. For example, if you wish to make a change because you become (or your spouse, domestic partner or dependent becomes) eligible for coverage under a Plan sponsored by another employer, you will be required to provide evidence that you have obtained or intend to obtain (or that your spouse, domestic partner or dependent has obtained or intends to obtain) that coverage. Please attach a copy of any documentation that you have regarding the change or event that has occurred.

NOTE: You also must complete a new Election Form to indicate the specific election changes you are requesting. The Employer will determine if you are eligible for any election changes you are requesting. Also, note that there are time limits for requesting election changes, so you should complete and submit this form as soon as possible after you experience one of the changes listed on this form (see your SPD for details).

PART A–STATUS CHANGE

You may change your elections due to a Status Change only if the Status Change affects your eligibility or the eligibility of your spouse, domestic partner or dependent for coverage under the Plan or under a plan sponsored by another employer.

Under penalties of perjury, by signing below, I certify that (i) to the best of my knowledge, the Status Change indicated below affected my eligibility or the eligibility of my spouse, domestic partner or dependent for coverage under the Plan, a plan sponsored by another employer by whom I am employed or a plan sponsored by the employer of my spouse, domestic partner or dependent, (ii) if I am dropping coverage for any person because of a change in eligibility under another plan, I have obtained or will obtain (within 30 days of the change in eligibility) coverage for that person under that other health plan, and (iii) the above election changes are being made due to, and are consistent with (Check One):

___ My marriage or the establishment of a domestic partnership.

___ The death of my spouse, domestic partner or dependent.

___ My divorce, legal separation, legal annulment or termination of domestic partnership.

___ The birth, adoption or placement for adoption of my child or my domestic partner's child.

___ The termination of my spouse's, dependent's or domestic partner's employment.

___ The commencement of my spouse's, domestic partner's or dependent's employment.

___ The reduction or increase in hours of employment (including a switch between part-time and full-time employment, a strike or a lockout, or the commencement or return from an unpaid leave of absence) by me.

___ The reduction or increase in hours of employment (including a switch between part-time and full-time employment, a strike or a lockout, or the commencement or return from an unpaid leave of absence) by my spouse, domestic partner or dependent.

___ A change in my eligibility for coverage, under a plan offered by my employer, resulting from a change in my employment status.

___ A change in my spouse's, domestic partner's or a dependent's eligibility for coverage, under a plan offered by my spouse's, domestic partner's or a dependent's employer, resulting from a change in employment status.

___ The attainment of a particular age by a dependent that causes him or her to qualify or cease to qualify for coverage under the Plan.

___ The change in student status of a dependent that causes the dependent to qualify or cease to qualify for coverage under the Plan.

___ The attainment of a particular age by a dependent or other change that causes him or her to become or cease to be a Qualifying Individual for purposes of dependent care flexible spending account benefits offered under the Plan.

___ The change in location of my residence or worksite.

___ The change in location of my spouse's, domestic partner's or a dependent's residence or worksite.

PART B–SPECIAL ENROLLMENT RIGHTS

Under penalties of perjury, I hereby certify that to the best of my knowledge, the change indicated below has occurred and that I am requesting an election change because of a special enrollment right that resulted from that change:

___ I have experienced a loss of eligibility for coverage under a group health plan or an insurance policy. (NOTE: A "loss of eligibility" occurs you are no longer eligible to be covered under a plan or insurance policy because you fail to satisfy the eligibility requirements for any reason. It also occurs when you reach a lifetime limit for benefits under a plan or if you are covered under an HMO or other plan that is limited to a specific geographic area and you move out of that coverage area. A "loss of eligibility" also occurs if you have COBRA coverage and you reach the end of the maximum COBRA coverage period (or you reach a lifetime limit on benefits). However, a voluntary decision to drop health coverage or a loss of coverage because the covered person fails to pay premiums is <u>not</u> a loss of eligibility.)

___ My spouse, domestic partner or dependent has experienced a loss of eligibility for coverage under a group health plan or an insurance policy. (See explanation of "loss of eligibility" above.)

___ I am covered or my spouse, domestic partner or dependent is covered under another employer's group health plan and that other employer has stopped contributing to the cost of that other coverage.

___ I have gained a dependent or a spouse because of a marriage, birth, adoption or placement for adoption.

___ I or my spouse or dependent was covered under Medicaid or under a State Children's Health Insurance Program (CHIP) and lost eligibility for that coverage.

___ I or my spouse or dependent have been determined by a government agency to be eligible for financial assistance from a State CHIP or Medicaid program to pay for a portion or all of the cost of coverage under the Plan.

PART C–OTHER CHANGES

Under penalties of perjury, I hereby certify that to the best of my knowledge, the change indicated below has occurred and that I am requesting an election change that corresponds to the indicated change because of that change (*Check One*) (*NOTE: The events marked with an asterisk (*) do not apply to coverage under a Health Care Flexible Spending Account. You may not change your Health FSA elections because of any of those events)*:

___ A change in my eligibility for coverage under Medicaid or under Part A, Part B or Part D of Medicare.

___ A change in my spouse's, domestic partner's or my dependent's eligibility for coverage under Medicaid or under Part A, Part B or Part D of Medicare.

___ A judgment, decree or order that makes another individual responsible for providing accident or health coverage for my covered dependent. I understand that I may not cancel coverage for my dependent unless I provide adequate evidence that the coverage required by the judgment, decree or order is actually being provided as required.

___ A significant change in the cost of coverage for a benefit other than dependent care flexible spending account under this Plan (subject to the Employer's determination).*

___ A significant change in the cost of coverage for dependent care flexible spending account benefits (subject to the Employer's determination). By signing below, I certify that the dependent care provider is not a close relative of mine, including a parent, grandparent, child, grandchild, brother or sister, niece or nephew, stepparent, stepchild, stepbrother or stepsister, son-in-law or daughter-in-law, mother-in-law or father-in-law or sister-in-law or brother-in-law.

___ A significant curtailment of coverage for a benefit under the Plan (subject to the Employer's determination).*

___ The availability of a new benefit option under the Plan or the significant improvement of an existing benefit option (subject to the Employer's determination).*

___ A change made by my spouse, my domestic partner or my dependent to an election for benefits under a cafeteria plan or another qualified benefit plan offered by my spouse's or my dependent's employer during an election period that corresponds to a period of coverage different from the period of coverage under this Plan.*

___ A change made by my spouse, my domestic partner or my dependent to an election for benefits under a cafeteria plan or another qualified benefit plan offered by my spouse's or my dependent's employer during a period of coverage.*

___ My spouse's, my domestic partner's or my dependent's loss of group health coverage sponsored by a governmental entity or an educational institution.*

___ My loss of group health coverage sponsored by a governmental entity or an educational institution.*

Date: _____ Signature of Participant:_____