**FAMILY STATUS CHANGE FORM**  
PMB 0141-1

**(BHR USE ONLY) Remarks:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
PS Initials: \_\_\_\_\_\_\_\_\_\_\_\_  
Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emp#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PS Initials:**

**Agency: Emp #**

Bureau of Human Resources

Benefits Program

3800 East Highway 34, Suite 1

Pierre, SD 57501

605.773.3148

[BenefitsWebsite@state.sd.us](mailto:BenefitsWebsite@state.sd.us)

COMPLETE AND RETURN THIS FORM **WITHIN 30 DAYS** OF THE QUALIFYING CHANGE IN FAMILY STATUS

**Please Note:** If you are adding a qualified spouse and/or dependent to your coverage, you will receive a dependent verification request in the **mail** from Dialog Direct, who is partnered with the State to verify dependent eligibility. If you do not provide the requested documentation to Dialog Direct, your qualified spouse and/or dependent will be removed from your coverage, and you will not be able to add them to your coverage again until Annual Enrollment.

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| **Employee Information** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name First Name MI Insurance ID SSN  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Address City State Zip  \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth Home Phone Work Phone Cell Phone  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email |

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| **Designation of Status Change** |
| “Change in Status” is the Internal Revenue Service rule that allows you to adjust your benefit selections when unforeseen circumstances occur between annual enrollments. Only specific events qualify as a change in family status. (Refer to the list below.) The IRS provides guidelines for family status changes and requires that you maintain legal documentation of the changes in your personal records. Examples of documentation include birth certificate, death certificate, marriage certificate, adoption papers, divorce decree, notice of legal separation, or proof of change in spouse or dependent’s employment. Documentation may be required upon request.  **Check the event that applies:**  \_\_ Birth/Bending Birth or Adoption \_\_ Death \_\_ Marriage \_\_ Divorce/Legal Separation \_\_ Eligible Dependent \_\_ Ineligible Dependent  \_\_ Beginning Employment \_\_ Incapacitated/Handicapped Dependent \_\_ Change in Dependent Care \_\_ COVID-19 \_\_ Other (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **This change occurred on \_\_\_/\_\_\_/\_\_\_\_\_.** |

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| **Coverage to be Added/Terminated** | | | | | | | | | |
| **Emp = Employee Sp = Spouse Ch = Child Indicate in the table either A (Add) or T (Terminate) for all plan changes** | | | | | | | | | |
|  | | | | | | Flexible Benefits | | | |
|  | Name | SSN | Date of Birth | Sex | Health | Dental | Vision | Accident Ins | Hospital Indemnity |
| EMP |  |  |  |  |  |  |  |  |  |
| SP |  |  |  |  |  |  |  |  |  |
| CH |  |  |  |  |  |  |  |  |  |
| CH |  |  |  |  |  |  |  |  |  |
| CH |  |  |  |  |  |  |  |  |  |
| CH |  |  |  |  |  |  |  |  |  |

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| **Tobacco Use** |
| **Are you a tobacco user? \_\_\_ Yes \_\_\_ No Is your covered spouse a tobacco user? \_\_\_ Yes \_\_\_ No** |

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| **When Adding Coverage** |
| Premiums are paid in advance of the effective date. If you elect coverage to be effective the date of the event, you are authorizing South Dakota State Employee Benefits Program to take a one-time deduction for additional premium(s) (if applicable) from your paycheck. Thereafter, regular semi-monthly or monthly premium will continue to be deducted from your paycheck.  **Health coverage should take effect \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_.**  **Flexible benefits (dental, vision, accident insurance and/or hospital indemnity should take effect \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_.** |

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| **When Terminating Coverage** |
| Central Payroll Employee (paid semi-monthly):  - Termination date can be the date of the event, the 15th, or end of the month in which the event occurred.  Regent Payroll Employee (paid monthly)  - Termination date can be the date of the event or the end of the month in which the event occurred.  **Requested Termination Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_.** |

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| **Spending Accounts** |
| **\*Medical Flexible Spending Account: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per pay period for a total of $\_\_\_\_\_\_\_\_\_\_ per fiscal year.**  **\*Dependent Care/Day Care Spending Account: $\_\_\_\_\_\_\_\_\_\_\_\_\_ per pay period for a total of $ \_\_\_\_\_\_\_\_\_ per fiscal year.**  **If adding a Medical Flexible Spending Account or Dependent Care/Day Care Spending Account, it should take effect:**  **\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_.**  **If terminating a Medical Flexible Spending Account or Dependent Care/Day Care Spending Account, the requested termination day is: \_\_\_/\_\_\_/\_\_\_\_\_\_.**  \*Expenses may be found in the Summary Plan Description at [https://bhr.sd.gov/benefits/FY20Files/FY20SPDFinal.pdf](http://benefits.sd.gov/spendingaccounts.aspx) or as described under the Internal Revenue Code at<http://www.irs.gov/pub/irs-pdf/p502.pdf> |

This is to certify I incurred a family status change(s), and wish to change my plan benefits as indicated on this form. I understand:

* *the change must be consistent with the family status change event and requested within 30 days of the event,*
* *I may be required to provide documentation according to IRS guidelines for the family status change and required to maintain legal documentation of the changes in my personal records. Examples of documentation include: birth certificate, death certificate, marriage certificate, adoption papers, divorce decree, notice of legal separation, or proof of change in spouse or dependent’s employment,*
* *if necessary; the South Dakota State Employee Benefits Program may take a onetime deduction from a future paycheck for the requested effective date (s), and*
* *the South Dakota State Employee Benefits Program reserves the right to verify family status changes during the plan year,* ***and Dialog Direct, the State’s dependent eligibility verification vendor, will send dependent verification request documents to employees who add a dependent to benefit coverage.*** *I could face disciplinary action and reduction or loss of my health benefits if I misrepresent family status changes for myself and/or my covered dependents. I could face disciplinary action and reduction or loss of my health benefits if I misrepresent family status changes for myself and/or my covered dependents.*

# Employee Signature Date Signed

## An electronic confirmation statement notice will be sent to your email address on file after the Family Status Change form has been processed.