



## QUALIFYING LIFE EVENT NOTIFICATION FORM

Please complete this form and submit to the Benefits Department within **thirty (30) days** of the Qualifying Life Event.

Employee Name: \_\_\_\_\_

Employee ID Number or Last 4 Of SSN: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

Date of Qualifying Life Event: \_\_\_\_\_

**Type of Qualifying Life Event:**

- Birth
- Marriage
- Divorce
- Legal Separation or Limited Divorce
- Adoption
- Guardianship
- Death (of a Spouse or Dependent)
- Loss of Coverage
- Gaining Coverage
- Change in Employment Status (Temporary to Full-time/Part-time)

<u>Dependent Name</u>	<u>Relationship</u>	<u>Social Security Number</u>	<u>Date of Birth</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Dependent Eligibility Verification through Aight Dependent Verification Center

Aight will send all active employees a personalized verification request via mail. Please review the time sensitive material in order to verify your eligible dependents. All documentation must sent to Aight using your Login and Password or fax cover page provided by Aight:

Upload: [www.yourdependentverification.com/plan-smart-info](http://www.yourdependentverification.com/plan-smart-info)

Secure Fax: 1-866-966-6881

U.S. Mail: **Dependent Verification Center**

P.O. Box 1403

Lincolnshire, IL 60069-1403

*\*If you do not provide the required documents your dependent(s) **will no longer** be covered by your Prince George's County Government benefits.*

By signing this form, I understand that I cannot make changes during the plan year unless there is a family status change and I complete a benefits form within 30 days of the event. Rules for the plan changes will vary depending on my status. This form authorizes any licensed physician, hospital or health care provider to furnish my health plan with such medical information about myself and any eligible dependent as needed. I understand that my coverage and benefits may be adversely affected by my failure to provide complete and accurate information.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_