Qualified Status Change Form

Personal Information

Name:	Employee ID#:	Hire Date:
Home Address: (Number, Street, City, State, Zip)		

Qualifying Event – If you have a qualifying event, you must submit this completed form to HR Benefits within 31 days from the event. Documentation verifying the event is required. For examples of acceptable documentation, go to the Summary Plan Description available at https://www.getty.edu/staff/forms/SPD_health/completeh&w.pdf.

☐ Birth/Adoption ☐ Marriage ☐ Same-Sex Partnership ☐ Death	☐ Divorce/Legal Separation ☐ End of Same-Sex Partnership ☐ Dependent Loses Other Coverage ☐ Dependent Becomes Eligible For Other Coverage	☐ Qualified Medical Child Support Order ☐ You Return From Unpaid Leave of Absence ☐ Moved Out of Carrier's Network Area	☐ Other - Please describe:

Eligible Members - Documentation verifying dependent eligibility is required. If additional space is needed, attach another form.

☐ Add eligible members listed below ☐ Delete enrolled members listed below ☐ Delete ALL enrolled members

Member	Last Name	First/M.I.	Date of Birth	Social Security Number	10-Digit PCP or Medical Group # **(HMO only)**
Employee				n/a	
Spouse/Domestic Partner					
Child					
Child					

Medical Plan *(includes vision coverage)*

☐ **Signature Value Advantage Plan – (HMO)** UnitedHealthcare - *Each family member must choose a Primary Care Physician (PCP) or Medical Group from the Signature Value Advantage Provider Directory.* Call UnitedHealthcare at 877.630.5898 to confirm your provider's participation in the network.

☐ **Signature Value Plan – (HMO)** UnitedHealthcare - *Each family member must choose a Primary Care Physician (PCP) or Medical Group from the Signature Value Provider Directory.* Call UnitedHealthcare at 877.630.5898 to confirm your provider's participation in the network.

☐ **PPO Plan –** Call Anthem at 800.759.3030 to confirm your provider's participation in the network.

☐ **Decline Medical and Vision Coverage** - *See Participation Terms & Conditions for important information.*

Dental Plan

☐ **Enroll in MetLife Dental Plan** ☐ **Decline Dental Coverage** *See Participation Terms & Conditions for important information.*

Participation Terms & Conditions

1. By making an election, I authorize the J. Paul Getty Trust to deduct from my earnings the required contributions for the plans I have chosen for myself and my eligible dependents on a pre-tax basis each pay period. Except as indicated below, this deduction will be taken on a pre-tax basis each pay period. Required contributions are subject to change on an annual basis. I understand that if I move into an unpaid status, I am required to pay the required contributions by the first of each month. If HR Benefits does not receive my payment by the due date, coverage for myself and dependents will be terminated.

2. If I enroll dependents, I understand that coverage for newly-added dependents is subject to HR Benefits approval. I understand that I am required to submit documentation verifying my dependent's eligibility by the end of Open Enrollment or within 31 days from the date my dependent(s) becomes eligible. Examples of such documentation include marriage certificate or birth certificate, adoption papers, or California Declaration of Domestic Partnership or equivalent.

   I certify that all enrolled dependents are eligible for coverage based on the definitions and rules in the Eligibility requirements specified in the Summary Plan Description available at www.getty.edu/forms. I agree that I will de-enroll them within 31 days if they lose eligibility.

   I further certify that all the information I provided is true to the best of my knowledge, under penalty of perjury. I understand that applying for or continuing coverage for a person who is not eligible or no longer eligible is a violation of the Getty's policies and is subject to disciplinary action, up to and including termination of employment. I also understand that I will be responsible for reimbursing the Getty for any expenses paid on behalf of the ineligible individual.

3. I am aware that if I decline medical, vision and/or dental coverage for myself and/or my dependent(s) because of other coverage, I may be able to enroll myself and my dependent(s) in a Getty-sponsored plan if I or my dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage for me or my dependents). I must request enrollment within 31 days after the date my or my dependent(s) other coverage ends (or after the employer stops contributing toward the other coverage).

   In addition, if I have a newly eligible dependent as a result of marriage/domestic partnership, birth, adoption, or placement for adoption, I may be eligible to enroll myself and my dependent(s). I must request enrollment within 31 days after the marriage/partnership, birth, adoption, or placement for adoption. If I do not enroll myself and/or my dependent(s) within 31 days of becoming eligible, I may enroll during the next Open Enrollment.

4. I understand that once I make an election, I cannot change my election until Open Enrollment unless I have a qualified status change as described in the Summary Plan Description available at www.getty.edu/staff/forms.

5. If I enroll an eligible same-sex domestic partner, I acknowledge that the employer contribution for my partner's medical, vision and/or dental coverage may be considered as taxable income, subject to FICA (Social Security and Medicare) and federal income tax withholding. I also acknowledge that the Getty encourages me to consult a tax advisor to determine the tax status of benefits provided to a same-sex domestic partner.

6. I acknowledge and accept all terms and conditions of the Getty-sponsored plans in which I have elected to enroll as stated in the Summary Plan Description available at www.getty.edu/forms.

7. I understand that the Getty-sponsored plans are required by law to protect the privacy of certain health information that may reveal my identity. If I specifically ask HR Benefits staff to intercede on my behalf, I am thereby consenting to the use of my protected health information by the Getty to resolve my problem. (For more information about the Getty's Privacy Policy, refer to the Summary Plan Description available at www.getty.edu/staff/forms.)

8. I further understand that if I choose coverage under the HMO and there is any dispute between myself (or any of my covered dependents) and the HMO, the dispute will be submitted to binding arbitration in lieu of a jury or court trial.

_____ _____

Signature Date

For HR Benefits Use Only: Effective Date: _____ Date Processed: _____ Processed By: _____

The J. Paul Getty Trust
Human Resources - Benefits
1200 Getty Center Drive, #400
Los Angeles, CA 90049-1681
310.440.6523
Benefits@getty.edu

Please retain a copy of this form for your records. You should receive ID cards within 14 days from the date the form is submitted to HR Benefits. If not, please call Anthem at 800.759.3030 or UnitedHealthcare at 877.630.5898.