Life Event Change Form

Please make a copy for your records and return the completed form, with required documents, to the Aureon HR Benefits Department via one of the following options *within 30 days of the life event*:

1) Fax form and documentation to: 866-256-0796
2) Email to HR.benefits@aureon.com
3) Mail to: Aureon HR, Inc.
   Benefits Department
   7760 Office Plaza Drive South
   West Des Moines, IA 50266

If you have any questions, please call the Aureon Benefits Department with any questions at 800-336-1931 option 3

Section A: Employee Information

Employee Name: _____Social Security Number: _____
Home Address: _____
Home Phone: (___)____-_____ Work Phone: (___)____-_____ Cell: (___)____-_____

E-Mail Address: _____

Section B: Major Life Event/Type of Event

Date of Life Event _____ Effective Date of change: _____

- o Marriage, reconciliation of legal separation - *copy of marriage certificate required*
- o Divorce, legal separation - *copy of page one of divorce decree required*
- o Birth or legal adoption of child - *social security number needed once available / copy of adoption paperwork required*
- o You or your spouse becomes eligible for Medicare - *copy of new coverage with effective date required*
- o Spouse gains employment or becomes eligible for benefits through employer - *copy of new coverage with effective date required*
- o Spouse loses, or is no longer eligible for coverage - *copy of loss of coverage with effective date*
- o Child(ren) gains or loses other coverage - copy of loss/gain of coverage with effective date required

Medical	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children

Medical Plan Name: _____

Dental	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children

Dental Plan Name: _____

Vision	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children

Medical Flex Spending Account
$_____ New Pay Period Deduction ☐ Waive Medical FSA

Dependent Care Flex Spending Account
$_____ New Pay Period Deduction ☐ Waive Dependent Care FSA

Health Savings Account (must be enrolled in a qualified HDHP medical plan)
$_____ New Pay Period Deduction ☐ Waive Health Savings Account

Dependent 1 Info:

Last Name: _____ First Name: _____ Date of Birth MM DD YYYY

Social Security Number - _____-_____-_____ Gender ___ Medical: Add ☐ Drop ☐ Dental: Add ☐ Drop ☐ Vision: Add ☐ Drop ☐

Relationship to Employee: _____

Dependent 2 Info:

Last Name: _____ First Name: _____ Date of Birth MM DD YYYY

Social Security Number - _____-_____-_____ Gender ___ Medical: Add ☐ Drop ☐ Dental: Add ☐ Drop ☐ Vision: Add ☐ Drop ☐

Relationship to Employee: _____

Dependent 3 Info:

Last Name: _____ First Name: _____ Date of Birth MM DD YYYY

Social Security Number - _____-_____-_____ Gender ___ Medical: Add ☐ Drop ☐ Dental: Add ☐ Drop ☐ Vision: Add ☐ Drop ☐

Relationship to Employee: _____

Please Read Carefully Before Signing This Form:

I have indicated changes to my benefit elections and I understand that these changes will remain in effect until the next annual election period unless there is a change in my family status as defined by the Plan. I authorize Aureon HR to reduce my earnings by the amount of these elections or take deductions for the after tax elections. I authorize the company to keep these elections in effect for any subsequent years unless I provide specific written notification in accordance with plan enrollment provisions.

Signature: ---------- Date: ----------