Total Rewards

NEW YORK STATE | NY Power Authority

Qualifying Change in Status Form

THIS FORM MUST BE RETURNED WITHIN 30 DAYS OF QUALIFYING EVENT

Part 1 – EMPLOYEE INFORMATION

Employee Name _____ Marital Status: ☐ Married ☐ Single

Employee Personnel # _____ ☐ MANAGEMENT ☐ IBEW ☐ UWUA

Date of Event Change _____ Location/Extension _____

Part 2 – BENEFIT CHANGES / ADD DEPENDENT(S) TO THE FOLLOWING PLAN(S)

☐ Medical – NYPA PPO	☐ Individual	☐ Family
☐ Medical – NYPA CHOICE (Management & UWUA only)	☐ Individual	☐ Family
☐ Medical – HMO _____	☐ Individual	☐ Family
☐ Vision – Davis (Management & IBEW only)	☐ Individual	☐ Family
☐ Dental	☐ Individual	☐ Family
☐ Other _____		

I request a change in coverage due to the following Qualifying Change in Status. (Check below all that apply.)
I understand such a request is subject to approval based on IRS regulations.

Part 3 – REASON FOR CHANGE AND DEPENDENT DATA

(a) Change in marital status: ☐ Marriage ☐ Divorce ☐ Legal Separation

New Spouse Name _____ Date of Birth _____ SSN _____

Ex-Spouse Name _____ Date of Birth _____ SSN _____

(b) ☐ Birth or adoption ☐ Acquired dependent with guardianship ☐ Death of dependent

☐ Change in spouse/domestic partner's employment/status: ☐ New Job ☐ Loss of Job

☐ Other: _____

Name _____ Date of Birth _____ SSN _____

Name _____ Date of Birth _____ SSN _____

Name _____ Date of Birth _____ SSN _____

Part 4 – Flexible Spending Accounts (FSA)

If you would like to change your election or start contributing to a Health and/or Dependent Care FSA, please indicate your new annual amounts below. To continue your participation, you must re-enroll each year during Open Enrollment.

Health Care FSA: ☐ Annual Amount _____ Effective Date _____

Dependent Care FSA: ☐ Annual Amount _____ Effective Date _____

I attest that the above information is true and accurate and that I have not misrepresented my family status. I understand I am required to provide documentation in support of this application (see list for valid forms of documentation). I understand that if I elect to participate in a contributory plan(s), I authorize NYPA to reduce my compensation each payroll period.

Employee Signature _____ Date _____

Type your name

Please return completed form to HR Services or your local HR representative.

For questions regarding benefits, contact HR Services at HR.Services@nypa.gov or 914-287-3114.

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Proof of Family Status Change (acceptable documentation)

Marriage - Marriage license

Divorce/legal separation - First and last page of divorce decree to include judges' signature

Birth or adoption - Birth certificate/adoption papers, (or satisfactory proof of support and guardianship if dependent child is other than your natural, legally adopted or stepchild residing with you)

Death of dependent - Death certificate

Change in spouse/domestic partner's employment status - Letter from spouse's employer or proof coverage has ended

Spouse/domestic partner becomes totally disabled - Attending physician's statement certifying total disability