



QUALIFYING EVENT FORM

7309 E 21st St N, Suite 110 | Wichita KS 67206 | 800-819-9571 | Fax 316-687-2113

INSTRUCTIONS: Please print and complete.

Employee Name		Social Security Number
Phone	Email	Employer Name

Identify the qualifying event which caused the loss of other medical coverage for you and your eligible dependents. You must submit the appropriate required documentation, proof of prior coverage, and a completed group insurance program enrollment/change application with this application. Application for enrollment must be submitted within 60 days of the qualifying event.

QUALIFYING EVENT

DOCUMENTATION REQUIRED

(Employer may or may not opt to provide this to Empower.)

- Death of spouse or ex-spouse
Copy of death certificate and written documentation from the employer on company letterhead providing names of covered participants and date coverage ends.
- Divorce
Copy of the signed divorce decree and written documentation from the employer on company letterhead providing names of covered participants, date coverage ends, and the reason why coverage ended.
- Legal separation
Copy of the agreed order of legal separation and written documentation from the employer on company letterhead providing names of covered participants, date coverage ends, and the reason why coverage ended.
- Loss of eligibility (does not include a loss due to failure to pay premiums or termination of coverage for cause)
Written documentation from the employer or the insurance company on company letterhead providing the names of covered participants, date coverage ends and the reason for the loss of eligibility.
- Loss of coverage due to exhausting lifetime benefit maximum
Written documentation from the insurance company on company letterhead providing the names of covered participants, date coverage ended and stating that the lifetime maximum has been met.
- Loss of insurance (does not include a loss due to failure to pay premiums)
Written documentation from the employer on company letterhead stating that coverage has been or will be terminated.
- Termination of spouse's or ex-spouse's employment (voluntary and non-voluntary)
Written documentation from the employer on company letterhead providing names of covered participants, date coverage ends and reason why coverage ended.
- Employer eliminated contribution to spouse's, ex spouse's or dependent's insurance coverage (total contribution, not partial)
Written documentation from the employer on company letterhead providing names of covered participants, date contribution amount changed and date coverage ended.
- Spouse's or ex-spouse's work hours reduced causing loss of eligibility for insurance coverage
Written documentation from the employer on company letterhead providing names of covered participants, date coverage ends and reason why coverage ended.

OR employee without coverage or with single coverage

- Acquires a new dependent — spouse (and adding other previously eligible dependents)
Copy of marriage certificate.
- Acquires a new dependent — newborn (and adding other previously eligible dependents)
Copy of birth certificate for newborn.
- Acquires a new dependent — adoption/legal custody
Copy of adoption documents.

Employee Name		Social Security Number	
Phone	Email	Employer Name	
Employee Signature		Telephone Number	Requested Effective Date
Employer's Signature		Telephone Number	Date Received from Employee