

**King County**Benefits, Payroll and  
Retirement Operations

# Qualifying Life Event

## Add Eligible Family Members to Medical Coverage

Phone 206.684.1556 ♦ Fax 206.296.7700 ♦ Email [kc.benefits@kingcounty.gov](mailto:kc.benefits@kingcounty.gov) ♦ Web [www.kingcounty.gov/employees/benefits](http://www.kingcounty.gov/employees/benefits)

Main Address Benefits, Payroll and Retirement Operations, Chinook Building CNK-HR-0230, 401 Fifth Ave., Seattle, WA 98104

- Use this form to enroll family members in medical coverage after a Qualifying Life Event. Additional documentation is also required.
- Submit this form **within 30 days** of your Qualifying Life Event. Forms may be delivered in person, faxed or scanned/emailed.
- If you do not submit this form within 30 days, the next opportunity to add a family member is the annual Open Enrollment (except for newborn and adopted children).
- To add Life and AD&D insurance, complete the *Life/AD&D Change* form. To enroll in/change an FSA, complete the *Flexible Spending Account Change* form. To change beneficiary information, complete the beneficiary forms.

### Indicate the Qualifying Life Event (choose one option only)

Event Date

- ☐ Marriage (attach a copy of your marriage certificate)
- ☐ Establishing state-registered domestic partnership (attach certificate of state-registered domestic partnership & proof of joint responsibility for basic financial obligations)
- ☐ Birth/adoption (attach a copy of the birth certificate or adoption/placement papers)
- ☐ Addition of a legal ward (attach a copy of court documents establishing legal custody)
- ☐ Loss of other coverage:
- Spouse (attach a copy of your marriage certificate **AND** proof of loss of other coverage)
  - State-registered domestic partner (attach certificate of state-registered domestic partnership **AND** proof of loss of other coverage **AND** proof of joint responsibility for basic financial obligations)
  - Child (attach a copy of the child's birth certificate **AND** proof of loss of coverage)
  - HMO plan participant no longer lives in the HMO service area

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### Provide information about your family members

Eligible Relationship Types Spouse • Domestic Partner • Child (Biological/Step/Adopted) • Domestic Partner Child • Legal Ward					
Relationship to Employee	Full Legal Name	Social Security #	Birthdate	Gender	Office Use Only: Dependent Verified?
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Date <hr/>
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Date <hr/>
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Date <hr/>
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Date <hr/>
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Date <hr/>
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Date <hr/>

Is your spouse/state-registered domestic partner a King County employee? ☐ Yes ☐ No

### Indicate the coverage you want for your family members (choose one option only)

- ☐ Enroll all eligible family members in health coverage (medical, dental, and vision)
- ☐ Opt out of medical coverage for all family members above (you cannot opt out of dental and vision coverage)
- ☐ Dental/vision only for my spouse/domestic partner, but health (medical/dental/vision) coverage for me and eligible children

**Note:** If you're in the Transit ATU 587 Part-time Partial Benefits Plan, you may add a family member for all or part of the health coverage you purchase for yourself. Call our office to discuss your options.

**Benefit Access Fee** (choose one option only)

If you cover a spouse or state-registered domestic partner on your King County medical plan, and you choose the KingCare PPO (Regence) medical plan, you pay a monthly Benefit Access Fee. If you qualify for an exemption, you must indicate the applicable exemption below, and again each year during Open Enrollment. If you later notify us that you qualify for an exemption and would like to discontinue the fee, that change will be made going forward, but you will not be refunded fees already deducted.

**Benefit Access Fee:** I choose to cover my spouse/domestic partner on my King County medical plan, and select the KingCare PPO medical plan and I agree to pay the following monthly Benefit Access Fee:

**Regular Employees (non-ATU 587 or Deputy Sheriff):**

☐ Benefit Access Fee for KingCare PPO (Regence) plan: \$125/month

**Transit ATU 587 Employees:**

☐ Benefit Access Fee for KingCare PPO (Regence) plan: \$150/month

**Deputy Sheriff Employees:**

☐ Benefit Access Fee for KingCare PPO (Regence) plan: \$75/month

**Benefit Access Fee Exemptions:** I qualify for the following exemption to the Benefit Access Fee:

☐ I am declining medical coverage, do not have a spouse/domestic partner, or am not covering my spouse/domestic partner.

☐ My spouse or domestic partner is a King County benefit-eligible employee.

☐ My spouse or domestic partner does not have access to medical coverage through an employer.

**Authorize your change**

This information is true, correct and complete and amends previously submitted information. I authorize King County to make any payroll deductions resulting from my requested changes. I understand the willful falsification of any information I have provided may lead to disciplinary action up to and including discharge from employment. If I'm adding a domestic partner and/or a domestic partner's children, I understand deductions based on the taxable value of their benefits will be deducted from my paycheck retroactive to the date coverage began. I understand that the Benefit Access Fee (BAF) resets each year and that I must go online during Open Enrollment to make any changes. I understand it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee signature \_\_\_\_\_ Date signed \_\_\_\_\_

Printed name \_\_\_\_\_ Employee ID# 0000 \_\_\_\_\_

Email address \_\_\_\_\_ Phone # \_\_\_\_\_

Office use only	Date received	Processed by	Audited by	Date effective
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